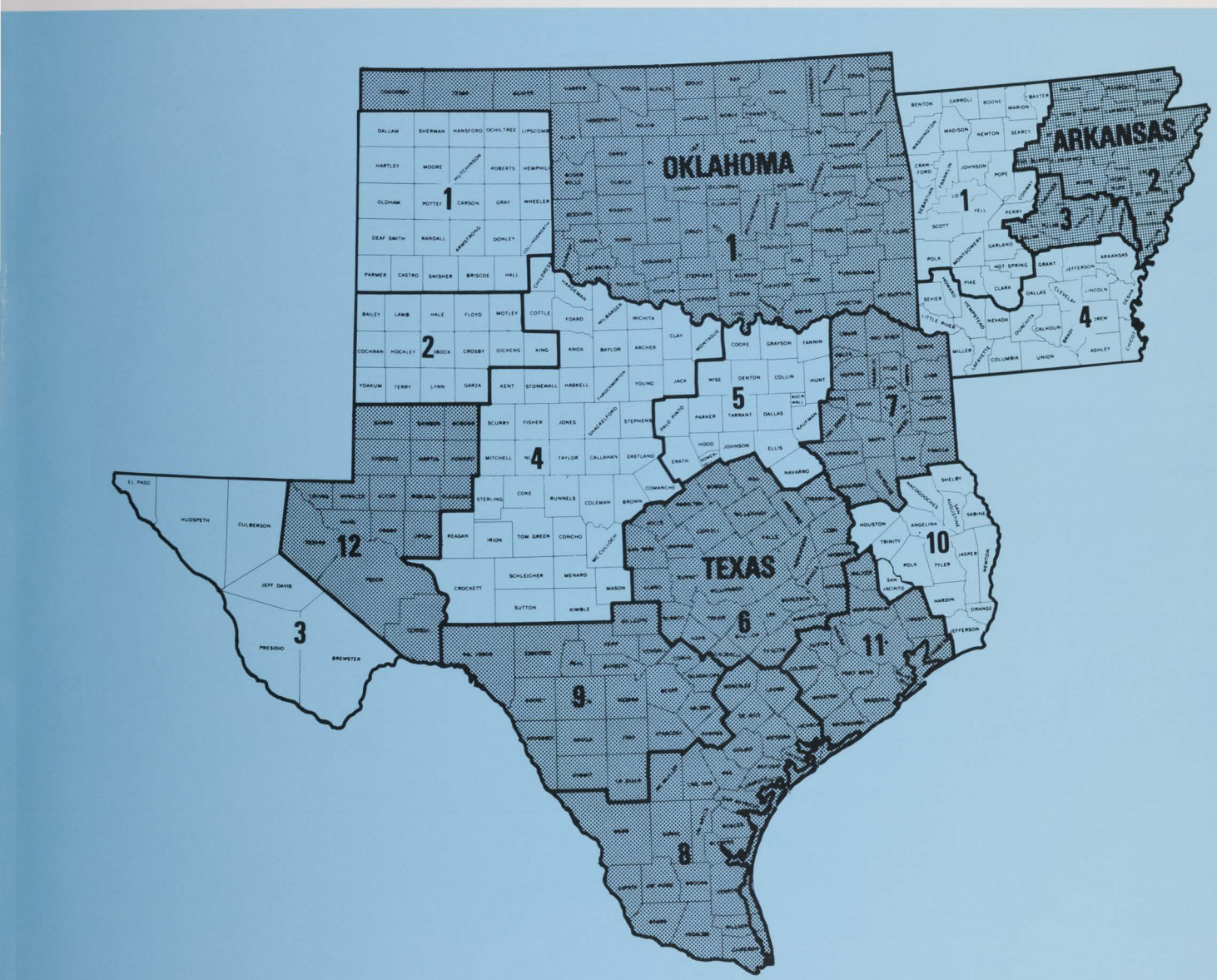
HEALTH PLANNING IN TRANSITION

STRUCTURE AND PERFORMANCE IN ARKANSAS, OKLAHOMA, AND TEXAS



LYNDON B. JOHNSON SCHOOL OF PUBLIC AFFAIRS
THE UNIVERSITY OF TEXAS AT AUSTIN

LYNDON B. JOHNSON SCHOOL OF PUBLIC AFFAIRS
POLICY RESEARCH PROJECT REPORT
Number 29

Health Planning in Transition

Structure and Performance in Arkansas, Oklahoma, and Texas

A Report by
The Health Planning in Transition Policy Research Project
Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin
1978

Library of Congress Card Number: 78-70526

FOREWORD

The Lyndon B. Johnson School of Public Affairs has established interdisciplinary research on policy problems as the core of its educational program. A major part of this program is the policy research project, in which a team of several faculty members, each from a different profession or discipline, and graduate students with diverse backgrounds work together on an important public policy issue. These projects are conducted in response to public and governmental needs.

This study describes and analyzes the implementation of the National Health Planning and Resource Development Act in three states as of spring 1978. The report was produced as part of a policy research project conducted at the School during 1977-78 under contract with the Region VI Office of the Public Health Service, Department of Health, Education, and Welfare. Additional funding for the publication was provided by the Lyndon Baines Johnson Foundation.

The intention of the LBJ School is to develop men and women with a capacity to perform effectively in public service and as a consequence of our program, to make available information that will enlighten and inform those in decision-making roles. The project which resulted in this report has helped to accomplish the former; it is our hope and expectation that the report itself will contribute to the latter.

Elspeth Rostow
Dean

PREFACE

This is the final report from a year-long Policy Research Project conducted at the Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, under contract to the Region VI Office of the Public Health Service, Department of Health, Education, and Welfare. The contract was issued:

> . . . for a study of the relationships that exist within Region VI between Health Systems Agencies and their respective population groups, between HSAs and their respective state agencies, and between the Federal government and each of the non-Federal components in an effort to understand and improve these relationships.

In approaching this project we decided to study three states and nine HSAs in Region VI so that we might look at these relationships in some depth.

After initial briefing sessions in October, we divided the project participants into groups to conduct specific case studies to be used as the basis for much of our analysis. The states to be examined were specified by the contract, while the individual HSAs were chosen for their diversity. The agencies selected and the students assigned to do case studies were: Arkansas SHPDA–Greg Schonert; Central Arkansas HSA–Dan Reingold; Delta Hills HSA–Melissa Freidland and Thomas Langheinrich; Oklahoma SHPDA–Harley Duncan; Oklahoma HSA–Gary Flynn; Oklahoma background–Sharon Slepicka; Texas SHPDA–Peggy Hamilton; South Texas HSA–Diana Comacho and Maria Mendez; Camino Real HSA–John Schulze; Central Texas HSA–Colette Knisely and Sara McLanahan; Permian Basin HSA–Ellen Juran and John Kemmy; Houston-Galveston HSA–John Kemmy and Barbara Weinberg; and Northeast Texas HSA–Betty King and Ginger Sampson.

After the completion of the case studies in January, five members of the project were delegated the explicit responsibility for preparing a draft of this final report. They were Harley Duncan, who prepared Chapter III and the bulk of Chapter VI; Gary Flynn, who prepared much of Chapter IV; Peggy Hamilton, who prepared Chapter II and a draft of some of Chapter VII; Colette Knisely, who prepared drafts of Chapters I and VII; and Dan Reingold, who prepared Chapter V. To a great degree these chapters are a joint effort, since the members of this group met regularly and at length to discuss, organize, critique and rewrite one another's work. In addition, Ellen Juran, Sarah McLanahan, Ginger Sampson, and John Schulze helped rewrite major portions of Chapters I and IV. The remainder of the class continued to serve as resources on their particular case studies on which this report is based. In addition, they devoted most of their efforts in the spring to organizing and preparing papers for a Conference on Organizing for Health Planning conducted in March 1978 here at the LBJ School. The proceedings of that conference, also partially subsidized by this contract, are available from the LBJ School Office of Publications.

This report has benefited from the cooperation of many people at each of the HSAs, SHPDAs, and SHCCs studied, respondents in both Washington and the Dallas Regional Office of DHEW, and experts who were willing to come and share their expertise with us. In addition to their continuing cooperation during the research, many of these same people commented on an early draft of this final report. Particular mention should be given the Dallas Regional Office which had the idea of experimenting with a contract of this kind and Willard Olsen who has been a very supportive and helpful project officer. Professors Emmette Redford and Milton Schoeman were kind enough to read the report and make a number of useful comments. Finally, special mention should be given to Marilyn Smiland, who has typed many drafts of this report and improved it each time she worked on it.

Our objective in carrying out this project and in preparing this final report has been to provide a thorough and fair picture of the implementation of the National Health Planning and Resource Development Act in three states at a point in time. Readers who are intimately familiar with the Act and its workings will of course want to skim much of the report–we have written it so as to be clear to the general citizen and student of government–but we do believe that experts in the field will also find a good deal of interest to them as well. The summary portion of the Summary and Conclusions is purposely detailed so that the busy reader can have access to an encapsulated account of our findings.

We hope that this report will add to the understanding of the emerging system for health planning which is being developed in these three states and the nation at large and help to short circuit some of the potential difficulties in the transition to the new system.

Dennis Thomas
David Warner

POLICY RESEARCH PROJECT PARTICIPANTS

Diana B. Camacho, *B.S. (Nutrition), Texas A&I University*
Harley T. Duncan, *B.A. (Political Science), South Dakota University*
Gary C. Flynn, *B.A. (Political Science), Swarthmore College*
Melissa Friedland, *B.A. (American Studies), The University of Texas at Austin*
Peggy C. Hamilton, *B.A. (Plan II), The University of Texas at Austin*
Ellen Juran, *B.A. (Political Science), State University of New York at Purchase*
John Kemmy, *B.A. (History), The University of Texas at Austin*
*Betty King, *B.S. (Public Health), University of North Carolina*
Colette R. Knisely, *B.A. (Government), The University of Texas at Austin*
Thomas Langheinrich, *Staatsexamen (Law), Albert Ludwigs Universitaet, Freiburg, Federal Republic of Germany*
Sara McLanahan, *M.A. (Sociology), The University of Texas at Austin*
Maria C. Mendez, *B.A. (Spanish), The University of Texas at Austin*
Daniel P. Reingold, *B.A. (Political Science), State University of New York at Albany*
Ginger Sampson, *B.S. (Political Science), University of Houston*
Greg Schonert, *B.A. (Political Science), University of Arkansas at Little Rock*
John Schulze, *B.A. (History), Rice University*
Sharon A. Slepicka, *B.A. (Political Science), University of Nebraska at Lincoln*
Barbara L. Weinberg, *B.A. (Psychology/Social Work), The University of Texas at Austin*

David Warner, *Associate Professor and* **Project Director**, *Ph.D. (Economics), Syracuse University*
Dennis Thomas, *Participating Faculty member, M.A. (Public Administration), The University of Texas at Austin*

*Audited fall semester only.

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CHAPTER I

INTRODUCTION TO HEALTH PLANNING

INTRODUCTION TO HEALTH PLANNING

The National Health Planning and Resources Development Act of 1974, Public Law 93-641, was signed on January 4, 1975. After many months of hearings and debates, the Congress had concluded that previous attempts by the federal government to plan for health services and to allocate resources in a rational manner had not been successful. Existing programs had failed to correct the over-supply of hospital beds and health professionals in some areas of the country and shortages in other areas. The earlier programs lodged authority for planning decisions in overlapping state and local agencies which often found their proposals unenforceable in the face of political opposition. Changes in the health planning system were considered essential before enactment of national health insurance legislation. Within this environment, the passage of P.L. 93-641 was intended to provide new and improved structure and support for effective health planning and a more systematic development of resources.

This act also marked a new level of federal intervention into the health care system. Earlier programs had involved the federal government largely in financing education, research, and capital improvements to the system, and in underwriting the care of the old and the poor. The passage of P.L. 93-641 signalled a desire on the part of Washington to find a legitimate way to set limits on how those funds should be spent. Thus, in an attempt to control federal spending, the government became deeply involved in what was—and remains—a largely private health care system. Indeed the Constitutional authority for the federal government to intrude into state and local activities relating to health and hospitals is based solely on its power to withhold federal funds to unplanned or unapproved programs and to states or localities which do not have a federally approved program of health planning and regulation.

PRIOR PROGRAMS

The legislation had evolved over a period of years and was based primarily upon the experience gained through the operation of three earlier federal programs: the Hill-Burton Program; the Regional Medical Program; and the Comprehensive Health Planning Program. Before turning to P.L. 93-641 it may be valuable to examine briefly the major features of these precursors.

Hill-Burton Program

The Hospital Survey and Construction Act (P.L. 74-725), commonly referred to as the Hill-Burton legislation, was passed in 1946 and marks the beginning of Congressional interest in health planning and resources development. The act was passed in response to an overall shortage of hospital beds coupled with maldistribution of hospitals between urban and rural areas after World War II. It tied allocation of resources for facilities construction to a state plan to meet those needs. Federal grants were then authorized for the construction and equipping of public and voluntary nonprofit hospitals and public health centers.

The Hill-Burton legislation was expanded in 1964 to include authorizations for long-term care facilities and for modernization or replacement of existing facilities. The program was further expanded in 1970 to authorize grants for the construction of neighborhood health centers and to establish priorities for facilities in rural and low income areas, for comprehensive health care facilities, for outpatient care in low income areas, for treatment of alcoholism, and for health and allied health training.

Regional Medical Programs

Regional Medical Programs (RMPs) were authorized by the Heart Disease, Cancer and Stroke Amendments of 1965. This legislation authorized planning grants, and was intended to establish regional cooperative arrangements among medical schools, research institutions, and health care institutions in order to make available to patients the benefits of advances in the diagnosis and treatment of heart disease, cancer, and strokes. The main focus of the program in the years up to 1970 was in improving accessibility of medical care through demonstration projects, coronary care training for nurses, and continuing education for physicians and health personnel.

The Public Health Service Amendments of 1970 ex-

panded the legislation to include planning and development of programs for the treatment of kidney disease. As a result of the national health priorities set forth in the 1970 amendments, the RMPs began to emphasize primary care services, the regionalization of health care resources, and improved use of health manpower in underserved areas. A provision was also included to allow the Comprehensive Health Planning agencies to review and comment on RMP grant proposals in their planning areas.

The result of this new emphasis was to redirect RMP programs from an essentially categorical to a more comprehensive health planning focus on health services delivery and manpower distribution.

Comprehensive Health Planning (CHP)

The Comprehensive Health Planning and Public Health Service Amendments passed in 1966 authorized support for comprehensive health planning to promote the development of a healthful environment and a health care system in which health care services would be available, accessible, and affordable for all persons.

Funding for health planning agencies was first authorized in the 1964 amendments to the Public Health Service Act. These agencies were areawide voluntary health facilities planning bodies established under Section 318 of the Public Health Service Act (PHSA). Many public entities and nonprofit corporations, with governing boards composed of health care providers and community leaders, were funded in major metropolitan areas to plan for the health care facility needs in their communities.

The 1966 amendments attempted to coordinate the existing health planning efforts and to respond to the criticism that planning for medical facilities without planning for health manpower, services, and other related activities would result in overcommitment of resources to expensive health facilities.

The legislation gave the CHP agencies a broad mandate to plan for all parts of the health care system. They were also given the authority to study the needs of their communities and to develop priorities for their planning efforts. The main health planning provisions of the legislation are as follows:

(1) 314a
- Authorized formula grants to states for state comprehensive health planning programs.
- Required states to designate a single agency (314a agency) to administer the state planning process.
- Provided for establishment of state health planning advisory councils with membership to be broadly representative of public and private health organizations and with consumers guaranteed a majority on the councils.

(2) 314b
- Authorized project grants for public or nonprofit organizations; the grants pay up to 75 percent of costs of operating areawide comprehensive health planning agencies (314b agencies).
- Gave the state 314a agency approval power over grants to areawide 314b agencies for the preparation of regional or local plans for health services, facilities, or manpower.

(3) 314c
- Authorized project grants to public or nonprofit private institutions or other organizations for training, demonstrations, or studies to improve comprehensive health planning processes and to develop qualified health planning staff.

The Comprehensive Health Planning legislation was amended several times between 1967 and 1973. These amendments expanded the scope of the CHP agency activities and provided for broader representation on the governing bodies and councils.

Perhaps the most significant change came through enactment of Section 1122 of the Social Security Amendments of 1972. Section 1122 disallowed Medicare and Medicaid reimbursement to health care facilities whose capital expenditures were determined to be inconsistent with state health plans. Recommendations of the areawide agencies were to be considered by the states in implementing this section.

PUBLIC LAW 93-641

The Health Planning and Resources Development Act of 1974 represented an attempt to rationalize the rather complex structure under the three programs discussed above. However, the new law itself created a virtual labyrinth of local, state, and federal agencies and functions. In part, this reflected a lack of Congressional consensus about which level of government was best suited to undertake health planning. But it was also a deliberate attempt to establish a complex system which could resist manipulation by special interest groups. As one Congressional source put it:

> The bill contains a kind of check and balance system between the federal, state, and local governments. That means that some things are going to take longer, levels of government will be getting into each other's way, but it also means that if the state medical society manages to get control of the state planning agency, they aren't going to have absolute control over everything that is going on in the state. (Quoted in John K. Iglehart, "Health Report/HEW Moves to Implement New Planning Regulation Program," *National Journal Reports*, January 25, 1975, p. 147.)

Issues Debated

Several issues were debated extensively during consideration of the act. One major point of contention focused on the question of consumer representation on HSA boards. There was general agreement that the HSA boards should be broadly representative of consumers, public officials, and providers, but the proper mix was widely disputed. Provider groups opposed majority representation for consumers, arguing that consumers have too little knowledge of the health care system to make intelligent choices. They blamed the requirement for majority consumer representation for much of the failure of the CHP agencies. Supporters of majority consumer representation countered that without a consumer majority, the HSA planning and regulatory functions would become self-serving instruments for providers. This argument carried the day, and consumers were guaranteed a majority on the HSA boards.

There seems to have been almost no questioning of the legitimacy of having health care providers on the board of an agency which would plan for and regulate their own profession. This is rather unusual as compared to other federal regulatory agencies, where industry representatives are prohibited from serving on the board or commission which regulates the industry. In this case, however, it was apparently assumed that the HSA boards would not have the necessary level of expertise if health care professionals were excluded. And, without professionals, it was perhaps feared that the decisions of local agencies would lack legitimacy.

The question of requiring or allowing states to regulate rates for insurance reimbursement of medical bills arose in both the Senate and House hearings. The AMA strongly opposed this provision, arguing that it would in effect turn the state agencies into utility commissions, with regulatory power over doctors' incomes. A compromise was finally enacted which authorized grants to up to six states for rate regulation demonstration projects.

A third issue involved the review and comment authority of the HSAs, and perhaps more importantly, their recertification authority. These powers were supported by critics of the old CHP agencies, who argued that the CHPs did not have enough authority to enforce their decisions. The recertification proposal drew the most attention. Supporters pointed out that the "Certificate of Need" provisions required that all new construction receive approval from the state. Without some type of recertification procedure, they argued, the Certificate of Need would provide a hospital franchise which could then never be reviewed, in effect creating a monopoly.

Even though this section of the legislation carried no sanction which could be imposed if the recertification review found a hospital to be unnecessary or duplicative, it was strongly opposed by the American Hospital Association (AHA). The AHA regarded recertification as a first step in a process that would grant government far more power over the way hospitals operate than it then enjoyed. The AHA also feared that recertification would adversely affect a hospital's ability to raise capital for new construction or modernization. In the end, Health Systems Agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) were given the deliberately ambiguous power to review the "appropriateness" of institutional health services in their area, without the authority to impose sanctions if they found an institution's services to be inappropriate.

The fourth issue to draw controversy involved the proper relationship of the HSAs to existing governmental units. Should the HSAs be private nonprofit entities or should they be lodged within local government units? Supporters of the private agencies argued that local governments were incapable of proper health planning because they were too susceptible to political pressures in support of new facilities. The House Commerce Committee pointed out, "It is always difficult for public organizations to limit growth or say no to new proposals."* Representatives of state and local governments countered by arguing that if HSAs were private nonprofit entities, they would be too powerful and too far removed from democratic control. As finally passed, the bill allowed either private nonprofit entities or—under certain conditions—public bodies to be designated as HSAs.

By encouraging the formation of private nonprofit entities to serve as HSAs, Congress was in effect trying to create a new system for health care planning and regulation. The authors of P.L. 93-641 seem to have envisioned a sort of collegial planning body insulated from the constraints of politics. The new system was to be at least one step removed from the existing political system at all levels—federal, state, and local.

Supporters

The major authors of the legislation in Congress were Representative Paul G. Rogers (D–Fla.) and Senator Edward M. Kennedy (D–Mass.), each of whom sponsored his own version of the bill. William R. Roy (D–Kan.) was another key House supporter of the legislation. There was a broad consensus within Congress for the reform of the health planning system and the twenty-eight-year-old Hill-Burton hospital construction program.

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*Report by the Committee on Interstate and Foreign Commerce, H.R. 93-1382, Washington, D.C.: U.S. Government Printing Office, 1974, pp. 40-41.

The Nixon-Ford Administration generally supported the legislation. Administration spokesmen argued, as did many members of Congress, that better planning was needed to hold down health care costs before national health insurance legislation could be passed. However, the Administration did criticize the bill's authorization level and the way it would allocate health planning and hospital modernization funds.

Opponents

Those opposed to the legislation or in favor of amendments were a collection of interest groups which had seldom agreed on anything else before. States and counties, physicians and hospitals were the major forces seeking to amend or block the legislation. The intensity of their interest was somewhat ironic because the existing agencies at that time had never been able to wield much influence. But the prospect of new legislation which would set up a network of agencies to help implement and monitor a national health insurance plan led to an intense jockeying for positions of influence over these future planning agencies.

The opposition was led by the AMA, which was most concerned with the proposal to regulate reimbursement rates. The American Hospital Association also opposed this provision, but the AHA concentrated most of its pressure on the recertification provision. Both organizations feared that the legislation would empower planning agencies to dictate what and when health services should be provided.

The AMA and AHA were joined by the National Governors' Conference, the National Association of Counties, and the U.S. Conference of Mayors, although their reasons were almost completely unrelated. The states, counties, and mayors were chiefly concerned with the proposal to prohibit designating public agencies as planning bodies. Oklahoma, where existing health planning agencies were public bodies, was particularly vocal in its opposition to mandatory private agencies.

Structure and Functions

The substantive elements of the National Health Planning and Resources Development Act are the structural and functional arrangements which create the health system itself. The Secretary of Health, Education and Welfare is given authority to issue guidelines in which two subjects must be addressed: standards for appropriate supply, distribution, and organization of health resources; and national health planning goals developed after consideration of priorities included in the Act.

Several levels of authority are initiated by the Act. The National Council on Health Planning and Development is a fifteen-member council appointed by the Secretary of DHEW. It advises the Secretary of development of the national guidelines for health planning and on the implications of new medical technology as it relates to delivery of health services.

The State Health Planning and Development Agencies (SHPDAs) are designated by the governor of each state and approved by the Secretary of DHEW. Each of these agencies is responsible for preparation of a draft of a State Health Plan to be submitted to the State Health Coordinating Council. Each SHPDA is to assist the State Health Coordinating Council in its performance of its functions. The SHPDA also is to serve as the 1122 agency and to administer the certificate of need program. In addition, the agency is to perform a review of the appropriateness of all health facilities in the state. With the Secretary's approval, any of these functions may be performed by another state agency.

The State Health Coordinating Council is appointed by the governor. Sixty percent of its members must be HSA board members and at least half must be consumers. The Council reviews and coordinates Health System Plans and Annual Implementation Plans from all HSAs within its state. It prepares an annual State Health Plan from the SHPDA draft, reviews HSA budgets and reports its comments to the Secretary, reviews HSA applications for planning and resources development assistance, and advises the state agency on the performance of its functions. Finally, it reviews and approves certain state programs for funding under several federal programs.

The Health Systems Agencies are the local planning agencies which serve designated health service areas. The agencies may be either private nonprofit organizations or public bodies. Each agency is to be governed by a board including at least a majority and not more than 60 percent consumers; the remaining seats are reserved for providers. The functions of the HSAs include: determining the status of health care delivery systems in the area and the effect of these systems on the health of the residents; recording the number, type, and location of the area's health resources; developing a health services plan with detailed goals and an implementation plan; reviewing and approving certain federal grants; recommending health facilities construction and modernization projects to the state; and reviewing the appropriateness of institutional health facilities.

The National Health Planning and Resource Development Act included authorization for initial HSA planning grants and for annual development funds if and when a given agency meets certain conditions. Centers for Health Planning were also created by the Act in each of the ten federal regions to perform a consultant function by providing assistance in planning and other mandated tasks.

Later Developments

P.L. 93-641 was due to expire at the end of FY 1977, but a one-year extension was passed early in 1977. This extension allowed the new Carter Administration and the Department of Health, Education and Welfare time to review the law and propose changes to it. These changes are currently being considered by both houses of Congress but no final action has yet been taken. The proposed reforms would not fundamentally alter the existing structure but would place a greater emphasis on regulation and cost containment. They would also move the system back toward the traditional political structure by giving a larger role to state governments.

Federal Implementation

Legislation is not implemented simply by Congressional enactment. There generally must be rule and regulation making at the federal level by some authoritative body and there must be some mechanism for the dissemination and enforcement of these regulations at lower levels of government.

In the case of P.L. 93-641 the Secretary of DHEW designated the Bureau of Health Planning within the Health Resources Administration as the agency responsible for implementing P.L. 93-641. The Bureau has been authorized to establish the policies and regulations prescribed by Congress in the health planning act and to carry out such functions as: issuing national planning guidelines; designating health service areas and agencies; issuing regulations; and providing technical assistance to the state and local planning agencies.

By early 1978 progress had been achieved in each of these areas. After much controversy concerning draft guidelines which had been issued in September 1977, National Planning Guidelines were issued by the Secretary of DHEW on March 28, 1978 with the advice of the National Council on Health Planning and Development. These guidelines fixed specific and quantitative standards relating to the utilization and/or prevalence of the following types of health services and facilities: general hospital beds, obstetrical inpatient services, neonatal special care units, pediatric inpatient services, open heart surgery units, cardiac catheterization units, radiation therapy, computed tomographic scanners, and end stage renal disease. Assuring the appropriate distribution and utilization of these resources and activities was seen by DHEW as an opportunity for short-term cost control.

The designation of the 213 health service areas was essentially completed by early 1978 and there are now 205 Health Systems Agencies designated under the terms of the Act. By May 1, 1978, seventy-one HSAs had been granted full designation. By the spring of 1978, all fifty-seven State and Territorial Health Planning Development Agencies had been conditionally designated, and by January 1, 1978, forty-one states had established Statewide Health Coordinating Councils (SHCC).*

In establishing regulations and guidelines for the development of Certificate of Need programs, Health Systems Plans, State Health Plans, and appropriateness reviews, the federal government has proceeded far more slowly. For example, federal guidelines for performance standards for HSAs were not forthcoming until March 1977, after 100 agencies had drafted Health Systems Plans and applied for continued designation. This delay at the federal level has caused confusion and additional delay at the state and local level in developing a cohesive planning process.

While the Health Resources Administration, the National Council on Health Planning and Development, and the Bureau of Health Planning are the rule makers in Washington, DHEW's ten regional offices are delegated administrative responsibility for enforcing central office policies and regulations, and facilitating federal/state/local relationships in health planning. Within the regional offices, the Health Planning Branches administer P.L. 93-641. Until recently this Health Planning Branch was part of the Bureau of Health Planning and Resource Development; however, in response to Congressional and interest group criticism, in 1977 HEW Secretary Califano placed the program directly under the Regional Health Administrators. This reorganization of regional offices was an attempt to recentralize policy control while reaffirming the administrative functions of the regional offices.

At the regional level, the first years of implementation were spent helping organize HSAs, SHPDAs, and SHCCs, interpreting the requirements of the federal law and regulations, and designating the state and local agencies. Regional office staff members supplied technical assistance to the state and local agencies applying for conditional and full designation, attempted to answer questions on application procedures and requirements, and monitored the state and local agencies' progress. In future years it may be expected that agency performance and procedures will be monitored regularly; but much of the detailed communication necessary in the first years will no longer be necessary.

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*The information in this paragraph has been distilled from the discussion in Section VI of the Report by the Committee on Interstate and Foreign Committee, entitled *Health Planning and Resources Development Amendments of 1978*, May 15, 1978, U.S. Government Printing Office, Washington, D.C., 1978.

In short, P.L. 93-641 has been law for nearly four years, and during that time Health Systems Agencies and state planning agencies have been designated and their duties have finally been delineated. The questions which currently trouble many observers are, "Can these institutions in their current structure effectively plan for and implement appropriate health services which are cost effective?" And, "Can this be done within a responsive intergovernmental structure in the context of American Democracy?" The evidence is not available to answer these questions. Our more modest task in this report is to examine, in detail, some of the actual structures mandated under the Act in Arkansas, Oklahoma, and Texas and to report on their performance through February 1978.

CHAPTER II

STRUCTURE OF STATE HEALTH PLANNING AGENCIES

New structures for health planning at the state level in Arkansas, Oklahoma, and Texas resulted from the passage of P.L. 93-641. The federal law mandates that each state designate a State Health Planning and Development Agency (SHPDA) and a Statewide Health Coordinating Council (SHCC). This chapter presents and compares for each state: (a) the provisions of the federal and state statutes relating to state structures; (b) the transition from the Comprehensive Health Planning structure to the new structure; (c) the state level structure in each state; and (d) an analysis of the state structure to determine whether it facilitates or impairs the accomplishment of the mandated functions.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Statutory Requirements

Statutory requirements of P.L. 93-641 for the State Health Planning and Development Agency are minimal (detailed in Section 1522). The SHPDA is to be designated by the Governor of the state. Agency designation remains conditional until such time as the Secretary of HEW determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a SHPDA. The SHPDA is required to have a professional planning staff and a development staff which meet the requirements of the Secretary in terms of size and qualifications (Section 1522[b] [4A]). In addition, the federal law allows for the performance of any SHPDA function by another state agency if requested by the Governor, and if the two agencies sign a coordination agreement which is satisfactory to the Secretary. The statutory requirements provide for flexibility and gubernatorial discretion in the designation of a SHPDA; as a result of this flexibility, each of the three states studied developed a distinctive state agency structure in response to its particular needs.

Activities in the States

Each state we studied has developed a different structure at the state level for implementing P.L. 93-641. In part, the structure selected was a result of each state's past experience with health planning. Political realities also determined agency structure to some extent. At this writing, Texas and Oklahoma are in their second year of conditional designation extending through June 30, 1978; Arkansas was granted full designation in the spring of 1978.

Arkansas

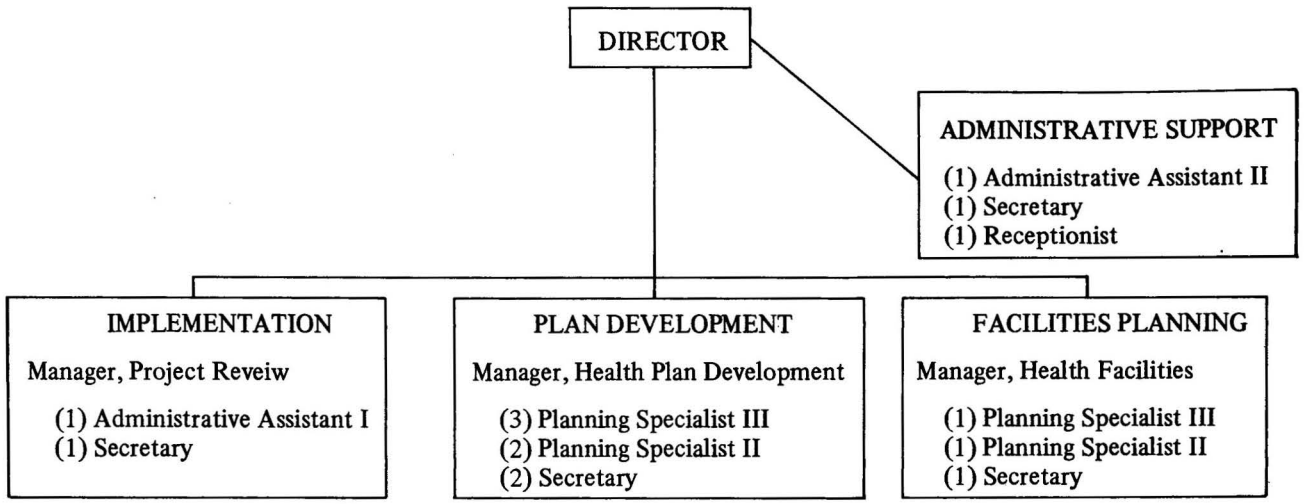
Arkansas' response to P.L. 93-641 is embodied in Act 558 (Arkansas Statutes, Art. 82-2307, et seq.), signed by the Governor on March 25, 1975. The Governor participated in drafting the enabling state statute which gives the Governor considerably more control over the state agency than is evident in either Oklahoma or Texas. Specifically, Act 558 provides for the establishment of the SHPDA, which is located in the State Department of Health for administrative purposes, but which is independent of the Department and under the supervision and control of the Governor. The Director of the SHPDA is appointed by the Governor and serves at his pleasure. The Governor must approve any contract between the SHPDA and another state agency for the administration of any program under P.L. 93-641.

Prior to the passage of Act 558, Arkansas had participated in the Comprehensive Health Planning program (P.L. 89-749) and in the Capital Expenditure Review program under Section 1122 of the Social Security Act Amendments of 1972 (42 U.S.C. 1320a-1). The 314(a) agency (created under the CHP program) was established in 1969 by Arkansas Act 305 as a part of the State Department of Health. This agency was also responsible for developing a State Health Manpower Plan as one of twelve states receiving funding from HEW for this purpose. Section 7 of Act 558 transferred all of the powers, duties, and functions of the Comprehensive State Health Planning Agency to the SHPDA. The Governor further facilitated the transition from the old to the new structure by appointing the director of the 314(a) agency to the directorship of the SHPDA. The current manager of the Plan Implementation Division was also a former employee of the 314(a) agency.

The Arkansas SHPDA has nineteen staff positions, including the Director. The agency is organized internally along functional lines with three divisions: plan implemen-

FIGURE 1

INTERNAL STRUCTURE OF THE ARKANSAS SHPDA



tation; plan development; and facilities planning. An administrative support unit operates out of the Director's office. Figure 1 illustrates the agency's internal structure and staff assignments.

It is evident that the agency has concentrated its resources in the division responsible for development of the state health plan. It appears that less emphasis has been put on the project review functions. However, it should be noted that this division received only seventy-one applications for project review under the state's Certificate of Need law and 1122 agreement for the period July 1, 1975 through December 31, 1976. The Facilities Planning Division, which prepares the facilities portion of the State Health Plan and the State Medical Facilities Plan also has fewer personnel than the Plan Development Division. This can be explained by the fact that the SHPDA contracts with the Bureau of Health Facility Services of the Arkansas State Department of Health for the conduct of certain activities under Title XVI of P.L. 93-641. For the period July 1, 1977 to June 30, 1978, the SHPDA is operating on a budget of $322,103, of which $237,246 is a federal grant and $84,857 is a state appropriation. Federal law provides that grants made to the SHPDA may not exceed 75 percent of the agency's operating costs (Section 1525[a]). In this case, the federal component of the Arkansas SHPDA's budget represents 74 percent of its total operating costs.

Oklahoma

Prior to the passage of P.L. 93-641, the State of Oklahoma participated in the Comprehensive Health Planning program (CHP). The 314(a) agency was located at various times in the Department of Health, the State Finance Office, and the State Planning Office of the Department of Community Affairs. In 1973, the Oklahoma legislature established the Oklahoma Health Planning Commission (OHPC) to assume the duties of the 314(a) agency. In 1974, the OHPC was given the additional responsibility of administering the Capital Expenditure Review program authorized by Section 1122 of the Social Security Act Amendments of 1972.

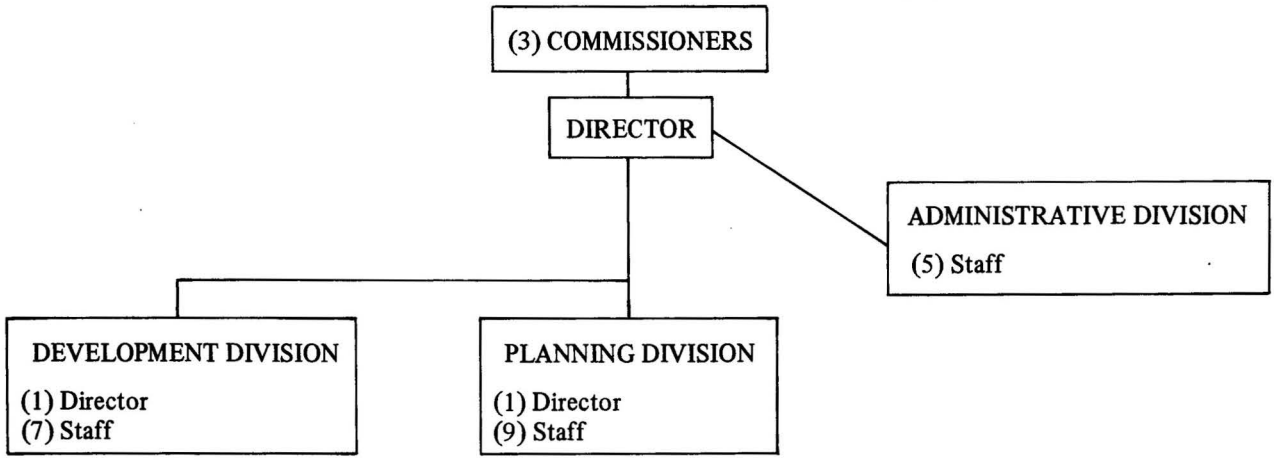
Prior to the passage of P.L. 93-641, the OHPC had no direct experience in administering a Certificate of Need program. A limited Certificate of Need statute relating only to nursing home construction was in effect prior to the passage of P.L. 93-641 (Chapter 63, 1971 Oklahoma Session Laws) and was administered by the State Department of Health. The state statute implementing P.L. 93-641 assigned the duties of the SHPDA to the already existing state agency, the Oklahoma Health Planning Commission.

Transition from the CHP structure to the new health planning structure was simplified by the designation of the OHPC as the SHPDA, with no significant changes in structure. The administration of the Certificate of Need statute relating to nursing homes was transferred to the OHPC to consolidate all the functions prescribed by the National Health Planning and Resources Development Act under one agency. The state agency structure in Oklahoma is authorized by state law embodied in Chapter 63, 1976 Oklahoma Session Laws, as passed by the legislature in 1976.

The Oklahoma Health Planning Commission has a unique structure which may be less responsive to the Governor than was envisioned in P.L. 93-641; at the same time, the structure may be more responsive to statewide needs because of its representative nature. The OHPC is a

FIGURE 2

INTERNAL STRUCTURE OF THE OKLAHOMA SHPDA



free-standing commission, a part of the executive branch of the state government. The Commission is comprised ex officio of the State Director of Public Welfare, the State Director of Mental Health, and the State Commissioner of Health. The commissioners are not appointed by the Governor, but are appointed to their primary positions by the State Public Welfare Commission, the State Board of Mental Health, and the State Board of Health, respectively, and serve as ex officio members of the OHPC. The commissioners in turn appoint the OHPC director.

Including the Director, the OHPC employs twenty-six full-time staff members. In order to administer the state program under P.L. 93-641, the staff of the OHPC was doubled. All of the current division directors had been with the OHPC prior to the new law. The three staff members responsible for administering the state's Hill-Burton program in the Oklahoma State Health Department joined the staff of the OHPC after the designation of that agency as the SHPDA, thus insuring staff continuity in this functional area. None of the current OHPC staff had been involved in the State Regional Medical Program, as that program had been phased out and its staff relocated prior to the passage of P.L. 93-641. Within the Commission, the staff is distributed among three divisions: Administration, Planning, and Development. Figure 2 shows the agency's internal organization and staff assignments.

The Planning Division has responsibility for the development of the State Health Plan and the State Medical Facilities Plan. The Development Division carries out project reviews of categorical grant programs and administers the Oklahoma Certificate of Need laws and the 1122 agreement. The structural organization does not, however, fully describe the division of responsibilities within the agency. While State Medical Facilities Planning is an element within the Planning Division, the monitoring of Title VI assurances and the Title XVI grants, loans, and loan guarantee functions are assigned within the Development and Administrative divisions. The state's Certificate of Need program has not been certified by DHEW as being in full compliance with federal regulations; the major reasons for the noncompliance of the Oklahoma Certificate of Need laws are that they do not explicitly cover all the necessary types of health care facilities and that the appeals procedures of the older nursing home Certificate of Need law do not conform to the requirments of P.L. 93-641. Despite this, the Commission appears to have emphasized the Certificate of Need function. However, for purposes of comparison, it can be noted that from July 1976 through June 1977, the Commission considered 122 Certificate of Need applications.

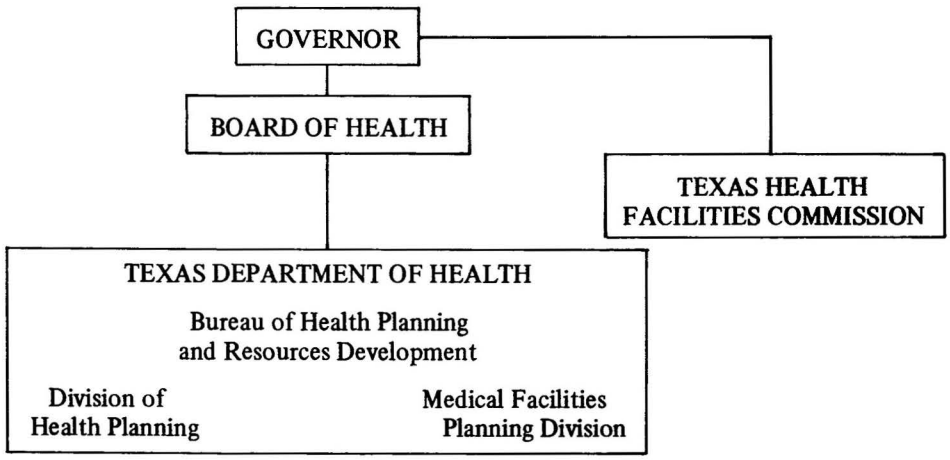
For the period July 1, 1977 to June 30, 1978, the Commission's operating budget was $515,780, of which $237,246 were federal funds and $278,534 was state appropriation. While this budget reflects a federal contribution of only about 46 percent of the agency's operating costs, it should be noted that of the state share, $93,534 is a one-time-only, nonrecurring state contribution.

Texas

Texas was one of the first states to pass enabling legislation to implement P.L. 93-641. This was due in part to the state's anticipation of the passage of the federal law, to the Governor's role in helping draft the state statute, and the legislature's willingness to compromise competing interests and avoid what could have been a debilitating conflict regarding the state agency structure. While P.L. 93-631 was being considered in Congress, the Regional

FIGURE 3

INTERNAL STRUCTURE OF THE TEXAS SHPDA



Medical Program (RMP) of Texas was turning its attention to the implications of the new law. In the fall of 1974, RMP funded the Health Legislation Policy Committee to analyze the state's possible response to pending legislation. Since P.L. 93-641 was passed while the Committee was making its study, the Committee was able to make specific recommendations as to the alternatives available to Texas in order to comply with the mandates of the new federal law. The Committee's recommendations were presented to the Governor in March 1975 in "A Report to the Governor: Recommendations for Implementation of the National Health Planning and Resources Development Act of 1974." The Committee proposed the creation of a new, independent agency to be designated as the SHPDA. A bill embodying this recommendation, drafted in the Governor's Office, was submitted to the legislature in March 1975. The major impediment to quick passage of the state law was the designation of the state agency. Many interests preferred designation of the State Department of Health rather than the creation of a new agency. The state structure which was eventually agreed upon demonstrates the compromise nature of the resulting state structure.

The compromise measure, Art. 4418, V.A.C.S., finally passed and was signed by the Governor on May 28, 1975. The State Department of Health was designated as the SHPDA, but a new agency, the Texas Health Facilities Commission, was created to administer the state certificate of need program. Under this structure the functions of planning and regulation are carried out by different agencies.

Prior to the passage of P.L. 93-641, Texas had participated in the Comprehensive Health Planning program since 1969. The state 314(a) agency was located in the Governor's Office and was named the Governor's Office of Comprehensive Health Planning. (For a short time the office was transferred to the Texas Department of Health; however, when P.L. 93-641 was passed the 314[a] agency was located in the Governor's Office.) This office participated briefly in the Capital Expenditure Review program, but the Governor declined to sign a formal agreement with the Secretary of HEW for continued performance of this function after the final federal regulations were published. At the time P.L. 93-641 was passed, there was no state Certificate of Need law, although legislative support for such a law had been coalescing for several years. The transition from the previous planning structure was more difficult in Texas because of the state's lack of experience with previous regulatory mechanisms.

The State Department of Health was designated as the SHPDA. This Department is headed by a Board whose members are appointed by the Governor according to a statutory formula prescribing which health care organizations will be represented on the Board. Board membership was extended from nine to eighteen members in 1975 in order to be more representative of the health care community. This expansion permitted the appointment of nonphysicians to the Board for the first time. The Board of Health supplies policy guidance to the Department. Recognizing the unique characteristics of the SHPDA, the Board of Health passed a resolution on June 1, 1975, creating the Bureau of Health Planning and Resource Development within the Department and assigning it the responsibilities prescribed in P.L. 93-641. The Bureau in turn is divided into two divisions: the Division of Health Planning and Development and the Medical Facilities Planning Division. Figure 3 illustrates the place of the SHPDA within the existing state agency structure.

The Texas SHPDA has a staff of seventy-three, the

largest of the three state agencies studied. Various members of the staff of the Texas SHPDA have had experience in previous health planning efforts. Two staff members had been employed by the Governor's Office of Comprehensive Health Planning, the state 314(a) agency. Four current staff members had been with the Regional Medical Program of Texas. Since the Hill-Burton program had been administered by the Texas Department of Health prior to the passage of P.L. 93-641, it required only an administrative directive to transfer this entire division, complete with staff, to the new Bureau of Health Planning and Resource Development.

The Texas SHPDA also has the highest level of funding of the three state agencies studied. For the period July 1, 1977 to June 30, 1978, the agency operated on a budget of $1,752,112, of which $1,314,084 was federal funding and $438,028 was a state appropriation. The federal support received by the Texas state agency represents exactly 75 percent of its operating costs, the maximum amount allowed by the federal law. It should be pointed out that none of the grant goes to support the state's certificate of need law, which is administered by another state agency, the Texas Health Facilities Commission.

In establishing its state agency structure, Texas took advantage of Section 1523(b)(1) of P.L. 93-641, which provides that any function of the SHPDA may be performed by another agency of the state government upon request of the Governor, under an agreement with the state agency satisfactory to the Secretary of DHEW. State law provides for the establishment of the Texas Health Facilities Commission (THFC) for the administration of the Certificate of Need program as well as for the performance of the appropriateness review function. The state law recognized the need for close coordination between THFC and the SHPDA, and provides for an administrative attachment between the two agencies. This is described in Section 2.01 of Art. 4418h, V.A.C.S., as follows:

> The department at the request of the commission, shall provide administrative assistance to the commission; and the department and the commission shall coordinate administrative responsibilities in order to avoid unnecessary duplication of facilities and services. The department, at the request of the commission, shall submit the commission's budget requests to the legislature.

In order for this structural arrangement to be accepted by DHEW, the two agencies were required to sign a coordination agreement detailing their separate responsibilities as well as their relationship for the performance of the Certificate of Need function. Such an agreement was submitted by the SHPDA in its first grant application in May 1976. The agreement, signed on April 30, 1976, was considered inadequate by DHEW and the first designation agreement was made conditional on the resubmission of a new coordination agreement.

DHEW ruled that the coordinative agreements provided for by the federal law implied that one agency must be in a primary relationship to the other agency, having some authority for that agency's actions. However, DHEW officials recognized that Texas law did not authorize the SHPDA to assume the role of the primary agency; rather, Texas law makes the two agencies independent with the exception of administrative linkages for avoiding duplication and waste. In June 1976, DHEW issued "Guidelines for Agreements for Performance of State Agency Functions by Agencies Other Than the State Agency," which set forth minimum requirements for acceptable coordination agreements. In response to these guidelines, an agreement between THFC and the SHPDA was drafted and signed on July 16, 1976, and subsequently approved by DHEW.

The Texas Health Facilities Commission (THFC) began operating on June 13, 1975. The THFC is under the direction of three full-time commissioners appointed by the Governor; the commissioners in turn hire an executive director and staff to administer the state's certificate of need program. The staff consists of twenty-seven full-time employees. The activities of the THFC are financed in part by a state appropriation and in part from fees charged for processing applications and from subscriptions to rules, notices, and agendas published by the agency. State law creating this dual agency structure in Texas prohibits the use of federal funds for the Certificate of Need program.

For fiscal year 1977, the Texas legislature appropriated $600,000 for the THFC's expenses. However, the THFC was able to collect $385,706 through application fees and charges. Actual cost to the state for fiscal year 1977 was $159,738 ($54,555 unexpended funds). The THFC expects to offset its fiscal year 1978 appropriation of $655,627 by fee collections in the amount of $470,000 so that the actual cost to the state will be $185,627. The fact that the THFC receives no federal funds serves to reinforce its independence from the SHPDA.

The Certificate of Need program in Texas is not yet fully certified as being in compliance with federal regulations. This noncompliance is due to differences between the state law and federal regulations (see also Chapter III). From November 1975 through August 1977, the THFC processed 610 Certificate of Need applications and 986 applications for exemption certificates or declaratory rulings. Should Texas decide to participate in the capital expenditure review program (1122 program), the THFC will be responsible for administering the program.

Summary

A review of the state agency structures established under P.L. 93-641 and the various state statutes demonstrates more variety than similarity. Although Arkansas has received full designation, Texas and Oklahoma are in their second year of conditional designation, and only Arkansas has a federally certified Certificate of Need program. The most significant differences among the three states stem from the philosophy of the states regarding the SHPDA's role, and from the role which the Governor appears to be assuming in each state with regard to the structure.

The philosophical differences noted are evidenced in the structural arrangements selected in each state. Arkansas demonstrates a structure independent of other state agencies in which the SHPDA Director can be appointed or removed by the Governor and is answerable directly to him. Additionally, the Governor must approve any agreements for the performance of any state agency function between the SHPDA and any other state agency. On the other hand, the SHPDA commissioners in Oklahoma are apointed by state agency boards or commissions and not by the Governor. This structure appears to insulate the SHPDA from direct gubernatorial control, while at the same time institutionalizing the representation of the three strongest health-related state agencies. The Texas structure resulted from a philosophical as well as political belief that the planning and regulatory functions should reside in separate agencies. Placing the SHPDA under the control of the Board of Health also insulates it from the Governor's influence, except where this influence can be applied to the Board itself. Enlarging the Board was a move to include a wider variety of health interests in the body having direct responsiblity for the operation of the Department, including the SHPDA.

The possible conflicts which these structural arrangements may cause (or mitigate) can only be speculated upon at this time. The most obvious case for a potential conflict is represented by the Texas structure, in which the SHPDA can receive direction from both the Board of Health and the Statewide Health Coordinating Council. The participants do not expect that this situation will necessarily result in conflicts of authority; however, it is plausible that such conflicts might result. The division of responsibility in Texas between the THFC and the SHPDA might also impair the overall program in Texas unless coordination between the two agencies is carefully worked out and followed.

In Oklahoma, the fact that the OHPC commissioners are each the principal officials in the state's three major health-related agencies could result in conflicts between the goals of the three agencies and the goals of the SHPDA. However, it is more likely that the formal state agency representation in the OHPC will prevent this type of conflict. The Arkansas SHPDA appears to be more independent of other state agencies than is the SHPDA in either Texas or Oklahoma. There is no formal relationship between the Arkansas SHPDA and other health-related state agencies. This situation may give rise to conflict with the SHCC or necessitate the Governor's arbitration of any conflicts over state goals which might arise.

The Governor's role in each state also points up structural differences. Only in Arkansas is the SHPDA directly under the control of the Governor. In Oklahoma and Texas the Governor's role is once or twice removed from the SHPDA's operations. If in the future the Governor's role is to be stronger, it is likely to be a result of functional responsibility rather than structural change.

STATEWIDE HEALTH COORDINATING COUNCIL

Statutory Requirements

Statutory requirements for the composition of the Statewide Coordinating Council (SHCC) are set out in Section 1524 of P.L. 93-641 and in the individual state statutes referenced previously. P.L. 93-641 requires that the SHCC:

- must have at least sixteen representatives appointed by the Governor from nominees submitted by each Health Systems Agency such that all Health Systems Agencies have at least two representatives and all shall have an equal number of representatives;
- must be composed in such a way that 60 percent of all SHCC members are representatives of the state's HSAs and 40 percent are appointed by the Governor as he deems appropriate; and
- must be constituted so that a majority (but not more than 60 percent) of its members are consumers and at least one-third of the provider members are direct providers.

Thus, although he appoints all of the members of the SHCC, the Governor may make only 40 percent of his appointments as he sees fit. In some cases, state law further curtails his autonomy.

Activities in the States

In each of the three states studied, the SHCC has been appointed, officers have been elected, committees assigned, and by-laws adopted. Each of the states is at a different point in the planning process, however, so that the activities undertaken by each of the SHCCs have varied. This chapter concentrates on the structural arrangements established for each SHCC. (See Chapter III for a discussion of SHCC functions.)

Arkansas

Act 558 of 1975 of the State of Arkansas authorized the establishment of a Statewide Health Coordinating Council. This law empowered the State Health Planning Council, established under P.L. 89-749, to act as the interim SHCC until the governing bodies of the four Arkansas Health Systems Agencies were formed. The interim Council served until the SHCC was appointed by the Governor on October 22, 1976. The permanent Council is composed of thirty-six members, including a representative of the U.S. Veterans Administration. Each HSA has three consumer and three provider representatives on the SHCC, selected by the Governor from nominees submitted by each HSA. Among the Governor's discretionary appointees serving on the SHCC are the Director of the State Health Department and the Director of the State Human Resources Department. The Governor apparently made these appointments voluntarily to insure representation of the interests of the two largest health-related agencies. State law does not require such appointments. Of the thirty-six members, the HSAs nominated 66.7 percent of the Council, and a 52.8 percent majority of the Council is consumers. All members are appointed for three-year terms. One-third of the providers and one-third of the consumers are replaced each year.

The SHCC has elected a chairman, as required by federal law, and a vice-chairman, each for one-year terms. The responsibilities of the SHCC are carried out through a committee structure.

- The *State Health Plan Committee* is composed of thirteen members who advise the state agency on the development of the preliminary state health plan. This committee, with subcommittees or task forces advising as appropriate, will develop for the SHCC recommendations for SHCC approval or disapproval of state plans and statewide project grant applications, including those submitted to DHEW under the Public Health Services Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention Act of 1970.
- The *Facilities Review Committee* is composed of eleven members who advise the state agency on the facilities portion of the SHP and the medical facilities plan, as well as on the state agency's administration of Title XVI fund applications.
- The *Executive Committee* is composed of twelve members, elected by the Council, who carry out SHCC functions between meetings and evaluate and advise the state agency on its management and support functions.
- The *Project Review Committee* advises the state agency on all requests for reconsideration of state agency decisions and evaluates the state agency's review process to assure its fairness, timeliness, and compliance of decisions with the state health plan.

Each SHCC committee is staffed by designated personnel from the SHPDA: the Director of the Arkansas SHPDA serves as liaison to the SHCC Executive Committee; the Manager of Project Review (Plan Implementation Division) serves as staff liaison to the SHCC Project Review Committee; the Manager for Health Plan Development (Plan Development Division) coordinates staffing needs of the SHCC State Health Plan Committee; and the Manager of Health Facilities (Facilities Planning Division) serves as staff coordinator for the SHCC Facilities Committee.

In addition to the SHCC committees listed above, the Health Manpower Planning Board serves as a committee to the SHCC. This board, composed of thirty members, is not an official part of the SHCC but is charged with advising the state agency on the development of the State Health Manpower Plan. Arkansas is the only one of the three states studied which receives federal funds for the development of such a plan. The plan, when developed, must be adopted by the Health Manpower Board and by the SHCC, and will be incorporated into the state health plan.

Oklahoma

The Oklahoma statute provides for the appointment of the SHCC membership in a manner which seeks to provide representation for specific groups. The constituencies represented on the SHCC are: consumer groups; medicine; osteopathy; third party payers; dentistry; hospitals; nursing homes; nursing; policy boards for public health, mental health, welfare, and higher education; Professional Standards Review Organizations (PSROs); advisory boards for education; and emergency medical services. The legal requirement is that Council members be appointed as follows:

- Sixteen members from nominees of the Oklahoma Health Systems Agency, Incorporated
- One member nominated by the Medical Director of the U.S. Veterans Administration
- One member of the State Senate nominated by the President Pro-tempore
- One member of the State House of Representatives nominated by the Speaker
- One member of the Physician Manpower Training Commission
- One member of the Emergency Medical Services Coordinating Committee
- One member of the State Regents for Higher Education
- One member of the Public Welfare Commission
- One member of the Board of Health
- One member of the Board of Mental Health
- One member of the Educational Council

- One member from nominees of the Board of Directors of the Professional Standards Review Organization.

In addition, two of the sixteen HSA members must be appointed from each of the state's six Congressional districts, with the remaining four appointed at large. In this way, geographic representation is assured. The SHCC members are appointed for three-year overlapping terms and no member may serve more than two successive terms. The first meeting of the Oklahoma Statewide Health Coordinating Council was held March 2, 1977.

To assist in discharging its responsibilities, the SHCC has elected three officers and organized five committees. The officers are: the President, who is responsible for presiding at all meetings of the SHCC; the First Vice President, who is to preside in the absence of the President and monitor the training and orientation obligations of the members; and the Second Vice President, who is to monitor the attendance of the members, membership classification, and the reporting of contacts on proposals before the Council, as well as assume the duties of the President in the absence of the other officers. The committees which have been established are:

- The *State Health Plan Development Committee* provides direct Council input into the SHP, develops a common plan format, approves a draft of the SHP, and conducts a hearing on the plan.
- The *Medical Facilities Advisory and Review Committee* represented the Council in the preparation of the State Medical Facilities Plan and presents the plan to the Council.
- The *HSA Review Committee* reviews and comments on the budget and grant application of the OHSA, and insures that HSA activities are coordinated with the SHCC and the OHPC.
- The *Committee on the Review of Program Proposals Administered by State Agencies* reviews and presents recommendations to the Council for approval on categorical grant applications.
- The *Operations Committee* provides leadership and direction to Council activities by developing procedures for the Council, evaluating the program, and serving as the principal liaison between the SHCC, OHSA, OHPC, the staff, and the Governor. The Committee also acts as the determination or appeals body on conflicts of interest, excused absences, training obligations, and Council actions to disapprove state agency applications. The Committee functions as an executive committee; its members are the three SHCC officers and the chairperson of each of the other committees.

SHPDA staff members are assigned to serve as staff to the SHCC on a committee basis, as follows:

SHCC COMMITTEE	*SHPDA STAFF ASSIGNED*
SHP Development Committee	Director of Planning Division
Medical Facilities Advisory and Review Committee	Director of Planning Division
HSA Review Committee	Director of OHPC
Committee on Review of Program Proposals Administered by State Agencies	Director of Development Division
Operations Committee	Director of OHPC

In addition to these assignments, a staff member selected by the Commission serves as a nonvoting Secretary to the SHCC. Additional staff assignments are made as necessary.

The structured representation of the SHCC is the result of the state's anticipation of the close coordination required by and among both public and private sector entities. It is believed that the necessary coordination will result if the entities which implement the HSP, SHP, and State Medical Facilities Plan (SMFP) are involved in the planning process.

The Governor's role in relation to the SHCC should be noted. The specific duties and responsibilities of the SHCC, as well as its bylaws, were set forth by the Governor in an Executive Order dated July 20, 1976. In Section 3 of the bylaws the Governor retains the right to remove a member of the SHCC for arbitrary or capricious failure to consider comments by theGovernor relative to the SHP. Since legally a governor has only review and comment authority regarding the SHP, this section of the bylaws appears to indicate that the Governor would like to take a more active role in development of the plan. The bylaws can be amended or repealed only by the Governor, thus reaffirming his desire for a role beyond that conveyed by the federal law (Executive Order, 7/20/76, Art. V).

Texas

In Texas, the forty-one members of the SHCC were appointed by the Governor for one- and two-year terms beginning October 21, 1977. The absence of a SHCC for some time after the Texas law authorized its existence was the result of several factors. The Governor had solicited nominations for positions on the SHCC from the state's HSAs in September 1976. Though nominations were relatively slow in being submitted, two further obstacles were present to prevent immediate appointment. First, the legislature was in session, and demanded a great deal of the Governor's attention. Second, a suit had been filed in Dallas

challenging the composition of that HSA's governing board in regard to low income and minority members. The Governor and his staff were reluctant to appoint SHCC members, in view of the possibility of the appointments being invalidated if HSA governing boards had to be reconstituted. The suit was not settled until the fall of 1977.

The delay in the SHCC appointments was a matter of some concern to the Dallas Regional Office of DHEW. In the first agreement designating the Department of Health as the Texas SHPDA, DHEW stipulated the condition that the SHCC appointments be no later than sixty days after the designation of all Texas Health Systems agencies. All of the HSAs were designated by September 21, 1976; however, the appointments to the SHCC had not been made when the DHEW-imposed deadline arrived. In fact, the SHCC appointments had not been made at the time the second conditional designation agreement was being negotiated. As a result, the second designation agreement was signed under the condition that all appointments to the initial SHCC be made by September 30, 1977. The Regional Office planned to terminate the agency's federal funds if this condition was not met. The condition was subsequently relaxed and appointments to the SHCC were made in October 1977.

The thirty-nine appointed members of the SHCC included two representatives of each HSA, nine physicians, and several public officials. No explicit representation of state level health-related agencies was made as in the other two states.

The SHCC has met once a month, beginning in November 1977. Officers have been elected (Chairman, Vice-chairman, Second Vice-chairman, Secretary), committees have been designated and members assigned, and bylaws have been adopted. The Council demonstrates a rigorous adherence to a 50 percent consumer and 50 percent provider mix on each of its operating committees. The SHCC by-laws establish the following committees:

- The *Executive Committee* acts for the SHCC between meetings of the Council and is responsible to the Council for the planning, development, and evaluation of all activities proposed or carried out under P.L. 93-641.
- The *Monitoring and Assessment Committee* makes recommendations to the SHCC regarding (1) base line and other data for program assessment; (2) measurement techniques for program assessment; and (3) where appropriate conducts reviews and evaluations of activities sponsored or conducted under HSA or state agency programs.
- The *State Health Plan Review Committee* makes recommendations to the Council regarding (1) the overall coordination exhibited in the Preliminary State Health Plan (PSHP) and among Health Systems Plans (HSPs); (2) specific recommendations addressing changes which may be required to deal more effectively with statewide health needs; and (3) the coordination and assimilation exhibited with other state agency health plans in drafting the PSHP.
- The *Annual Implementation Plans Review Committee* reviews and makes recommendations to the Council regarding (1) the HSP and AIP linkages exhibited and the logical alternatives for action addressed in the AIP; (2) the overall coordination of efforts between HSAs and their AIPs; and (3) the specific actions which would be required to assure that the AIPs are in concert with statewide implementation objectives.
- The *State Medical Facilities Plan Review Committee* reviews and makes recommendations to the Council regarding (1) the general administration of the SMFP; (2) the adequacy of the current statewide inventory of existing medical facilities; and (3) the coordination of a statewide needs survey and the plans of the HSAs.
- The *Application, Budget, and Project Review Committee* reviews and reports on (1) HSA applications and budgets; (2) state plans or other applications submitted to DHEW for funding under P.L. 93-641, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention Act of 1970; and (3) other health-related projects under the A-95 review process.

The SHPDA provides for a designated staff member to serve as liaison to each of the SHCC committees as follows:

SHCC COMMITTEE	*SHPDA STAFF ASSIGNED*
Executive Committee	SHPDA Director
Monitoring and Assessment Committee	Planner, Division of Health Planning
SHP Review Committee	Senior Planner in Charge of SHP Development
AIP Review Committee	Planner, Division of Health Planning
SMFP Review Committee	Director, Medical Facilities Planning Division
Application, Budget, and Project Review Committee	Senior Staff Person for Project Review

Staff assignments are made according to a determination of which SHPDA staff member has expertise in a particular area. Additional staff may be assigned as necessary.

Summary

The various state SHCCs demonstrate a similar structural organization with functionally oriented committees. The major difference among them lies in the requirements for the appointment of members. In Oklahoma, the Governor must make his discretionary appointments to the Council from state agencies specified in the state statute. In Arkansas and Texas, the Governor's appointments are discretionary.

The composition of the Oklahoma SHCC may be a cause of conflict in the future. The State Health Plan is to be based in part on the Health Systems Plan developed by the Oklahoma Health Systems Agency. Sixty percent of the members of the SHCC are representatives of the OHSA. As a result, any conflicts between the HSP and the SHP could conceivably be decided in favor of the HSA. However, this potential problem is partially mitigated by the unusual provision in the Oklahoma statute which gives the OHPC final authority to adopt the State Health Plan. In approval of categorical grants, there is a potential for conflict between the representatives of the HSA and the SHCC members who represent the state agencies administering these categorical programs. To avoid such conflicts, the Oklahoma SHCC (and all other SHCCs) must attempt to insure that the SHCC reflects a statewide perspective, and not necessarily the perspective of the HSA or of a particular state agency or state program.

Some potential problems may exist in Texas due to the state structure for health planning, particularly the several state entities involved. There is considerable speculation as to the role of the Board of Health and that of the SHCC. As a part of the State Department of Health, the SHPDA is answerable to the Board. At the same time, it must follow the leadership of the SHCC. The Board of Health retains the authority it has always held in approving the state's medical facilities plan and in granting funds to applicants under Title XVI. Similarly, the Hospital Advisory Council has an advisory responsibility to the Board for the compilation of the medical facilities plan. At the same time, the SHCC must approve the SMFP and is to advise the state agency on the administration of Title XVI.

Thus, in Texas three agencies have an advisory role or authority in regard to the SMFP. This authority will need to be carefully delineated and coordinated to avoid conflicts in the future. In Texas the SHCC does not provide the forum for representation of state agency interests, as it does in Oklahoma, and to some extent in Arkansas. In Arkansas, the Governor used his discretionary appointments to assure representation of the State Health Department and the State Human Resources Department. Established state agencies which are denied customarily-received categorical grants may come into conflict with the SHCC. Again, the smooth functioning of these agencies will depend on the degree of coordination and cooperation which can be achieved given the existing state planning structure. As Chapter III reports, such coordination is being achieved to some degree in the planning function, in that the various SHPDAs are attempting to involve as many state agencies as possible in order to avoid any potential conflicts.

Additionally, it should be noted that in Texas, since the Certificate of Need program is administered by an agency of the state other than the State Health Planning Agency, the SHCC has no apparent authority over the certificate of need program or the Texas Health Facilities Commission which administers it. It appears that the SHCC's influence on this program will be confined to such influence as it may exercise in the approval of the State Health Plan and State Medical Facilities Plan, which are to be the basis of decisions made regarding the granting of certificates of need.

In response to the requirements of P.L. 93-641, each state has established state agencies to fulfill the mandates of the federal law. It is too early to assess Congressional wisdom regarding the structures required for health planning; potential problems with the structures selected by each of the states have been suggested. Potential problems which might result from the structural arrangements selected by each of the states may be mitigated somewhat by the formal or informal processes which the agencies use in the performance of their functions. Interests which are not represented in the structural arrangements may be incorporated in the process of developing a state health plan, medical facilities plan, and in the project review procedures. The way in which the three state agencies perform their mandated functions will be described in the following chapter.

In addition, the types of interrelationships which agencies at the state level have formed with the federal government, as well as with other state agencies and statewide organizations, should be considered. Formal and informal relationships reflect the adequacy or inadequacy of the planning and decisionmaking which might not be apparent from an examination of only the legal structures and requirements. These relationships will be the subject of Chapter VI.

CHAPTER III

PERFORMANCE OF FUNCTIONS BY THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES AND THE STATE HEALTH COORDINATING COUNCILS

This chapter discusses and analyzes the manner in which the State Health Planning and Development Agencies (SHPDAs) and the State Health Coordinating Councils (SHCCs) in the states of Arkansas, Oklahoma, and Texas perform the functions assigned them in P.L. 93-641. We group these functions into two general categories: (1) plan development; and (2) plan implementation, which is composed of the several review-and-comment and review-and-approval functions assigned to the SHPDAs and SHCCs. The analysis of each function includes: (a) a brief review of the relevant provisions of P.L. 93-641 and the implementing federal regulations; (b) a discussion of how each function is being performed in the three states; (c) an identification of the key areas within each function where conflict has arisen or potentially could arise; and (d) an analysis of the key elements in the operations of each state which may serve to mitigate or resolve these conflicts.

PLAN DEVELOPMENT

Under P.L. 93-641, SHPDAs and SHCCs are responsible for two primary planning functions: (1) the development of a State Health Plan (SHP) and (2) the development of a State Medical Facilities Plan (SMFP).

THE STATE HEALTH PLAN

Statutory Responsibility

Section 1524 (c)(2)(A) of P.L. 93-641 charges a SHCC with the responsibility to prepare, at least annually, a SHP which is to be compiled from the Health Systems Plans (HSPs) prepared by the state's HSAs. The SHCC is authorized to review the HSPs and direct the HSAs to revise them as necessary, to accomplish two purposes: (1) "to achieve their (the HSP's) appropriate coordination," and (2) "to deal more effectively with statewide health needs."

In preparing a SHP, the SHCC is to "review and consider" the Preliminary State Health Plan (PSHP) developed by the SHPDA under section 1523(a)(2) of the Act. The PSHP is also to be composed from the HSPs of all HSAs in the state. In addition, it is to contain an assessment of statewide health needs and an analysis of state health policies and programs as reflected in state and federal law and in the operation of state health programs. The PSHP is also to contain such revisions of the HSPs as is felt necessary by the SHPDA "to achieve their appropriate coordination or to deal more effectively with statewide health needs." It is to be submitted to the SHCC for approval or disapproval and for use in developing the State Health Plan.

In documents interpreting the statutory language regarding the SHP, it is described as (a) a coordinated and comprehensive approach to the identification and resolution of health problems in the state; (b) an articulation of state health and health-related policies; and (c) a guide to resource allocation to achieve equal access to quality health care at a reasonable cost. It is seen as a "fusion and reconciliation" of all health planning activities in the state. The SHP is to be used by the SHPDA and SHCC in most of their other functions, including developing the SMFP, 1122 review, Certificate of Need reviews, review of state agency plans and applications, allocation of Title XVI funds, and reviews of HSPs, AIPs, and HSA budgets and work plans.*

The SHP is to be the cornerstone of the health planning, development, and regulation functions performed at the state level under P.L. 93-641. Similarly, the HSPs, of which the SHP is to be composed, are the cornerstones of health planning, development, and regulation at the HSA level. It seems that developing a SHP could cause conflict between the state agencies and the HSAs and is likely to be a key determinant of the relationship between the state agencies and the HSAs. The need is to develop a SHP which incorporates statewide health needs, but leaves the HSPs capable of meeting areawide health needs. This seems to require a coordinated planning process between the state and areawide levels. The SHPDAs and SHCCs will need to walk a fine line to develop a SHP which is capable of meeting health needs identified at the local and areawide levels. The SHCC is the body called upon to accomplish this coordination and reconciliation. The composition of the SHCC is, therefore, quite important to the form this

*Department of Health, Education and Welfare, "Draft Guidelines for the Development of a State Health Plan" (Washington, DHEW), May 12, 1977.

reconciliation will take. By law, 60 percent of the SHCC members must be representatives of the HSAs in the state.

The Department of Health, Education, and Welfare published a document entitled "Draft Guidelines for the Development of a State Health Plan" (May 12, 1977), which was intended to provide policy guidance for the development of a balanced and flexible SHP. The document is, however, quite vague on how the HSPs are to be integrated into an SHP. It states that the SHPDA and SHCC should take the lead in issuing planning guidance to the HSAs. Particularly, this guidance should include a common plan format or organization and a time frame for plan development. In addition, the DHEW guidelines direct SHPDAs to analyze state health policies and programs and to identify statewide health needs. The document also suggests possible situations under which the SHCC could order revisions of HSPs in order to conform to the SHP. Generally, these include situations in which state government has primary responsibility for the service, where the health care problem is better addressed on a basis larger than a single HSA, or when there are overlaps or gaps in services.

The development of a SHP based on the HSPs has been made difficult during this first plan development cycle because of the timing of events. In order to obtain full designation, HSAs have been pressured to develop their HSPs as early as possible. Similarly, SHPDAs and SHCCs have been forced to begin development of the SHP without the benefit of completed HSPs. In fact, the May 1977 guidelines for developing a SHP, urging states to take the lead in developing planning guidance, were issued about four months after draft guidelines for the development of HSPs were issued. Consequently, state-issued planning guides to the HSAs were generally issued after the HSAs had initiated their planning process. In addition, the SHCC, which was responsible for formally promulgating the planning guidance, was often the last body formed under P.L. 93-641. The result has been a confusion of functions and responsibilities in the planning process. This confusion is expected to be clarified to some degree in the next planning cycle, when all agencies can proceed on a more consistent basis.

Activities in the States

The three states studied in this project have approached the development of a State Health Plan in a substantially similar fashion, although the emphasis varies from state to state. In general, the states have accomplished the following activities:

- developing planning guidance consisting of, at least, a common HSP/SHP format;
- establishing a process for the identification of statewide health needs and policies;
- providing technical and information assistance to HSAs in the development of their HSPs; and,
- establishing a committee of the SHCC to guide the development of the SHP.

It should be noted that at the time of this study, none of the three states had reached the point where they had attempted to integrate the HSPs and the statewide planning activities into a State Health Plan. The SHPDAs in these states had not completed the Preliminary State Health Plan, and in only one state, Arkansas, had all HSAs developed their HSPs. In other words, none of the states had reached the critical juncture at which the HSPs must be integrated with statewide health planning activities to form a SHP.

Texas

The Texas SHPDA appears to have most vigorously pursued the development of a SHP among the states reviewed. In early 1976, the SHPDA, in consultation with the HSAs, DHEW, the Region VI Center for Health Planning, and other state health-related agencies, published a common HSP/SHP plan organization and coding format. Despite its volume, this document was basically a taxonomy for health planning. It identified the areas which should be addressed in a comprehensive health plan and discussed how goals and objectives, as defined in P.L. 93-641 and federal guidelines, should be written. It contained little substantive discussion to guide the integration of HSPs into a SHP, but did include a common coding format which should, if followed, allow easy comparison among HSPs and between these and the SHP. This document is seen as the primary policy guidance to be given by the SHPDA to the HSAs for developing their HSPs. Because the SHCC was not formed at the time this document was published, it has not yet been approved by the SHCC. It will be recommended to the SHCC for approval as the common HSP/SHP format to be used in Texas. At this time, it appears that a majority of the HSAs in the state are using the format.

The Texas SHPDA has also established a process for identifying statewide health needs, priorities, goals, and policies. It has formed an Interagency Task Force on State Health Planning, comprised of representatives of approximately fifteen health-related state agencies, to guide and direct this process. The Task Force was also involved in developing the planning and coding format described above. The process used by the SHPDA is a questionnaire submitted to fifty-four state health agencies and private health organizations asking for a ranking of statewide health needs and methods of addressing them. The results

of this survey will be used to develop an "interim" Preliminary State Health Plan in April 1978. The interim PSHP will be submitted to the HSAs for review and comment prior to submission to the SHCC in October 1978 as the Preliminary State Health Plan. The Texas HSAs have not been extensively involved in the development of this interim PSHP.

In addition to this activity, the SHPDA is currently identifying state health policies as contained in federal and state laws and programs and attempting to track the use of federal health-related grant funds in the state. Both of these efforts will also be used in the SHP, as required by the federal guidelines. They are, however, viewed by the SHPDA staff as being rather unproductive efforts because they provide little information as to actual health care needs and delivery systems.

Although the Texas HSAs are not extensively involved in developing the statewide portions of the PSHP, the SHPDA and HSAs have worked together on health planning, particularly in regard to data which the SHPDA can provide to the HSAs for use in developing their HSPs. An HSA Data Task Force, comprised of HSA and SHPDA staff members, was formed in 1976 and developed a minimum data set to be provided by the SHPDA to the HSAs. As part of the SHP and to provide assistance to the HSAs, the SHPDA has published a document entitled "Selected Health Data: Texas 1977" containing most of this minimum data set. Some Texas HSAs still cite the inability to obtain workable data in an appropriate format from the state as their major problem in developing their HSP and as the primary strain on their relationship with the SHPDA. The SHPDA has attempted to respond to the HSAs' data needs, albeit not always successfully. In addition to this data assistance, the SHPDA has assigned one staff member to each HSA to act as liaison with and provide technical assistance to the HSA.

The final activity regarding the SHP undertaken by the State of Texas has been to form a State Health Plan Review Committee of the SHCC. Because of the late formation of the Texas SHCC, the Committee has done little so far, but its responsibility is to make recommendations to the SHCC on (a) the overall coordination of the PSHP and the HSPs; (b) changes necessary to deal more effectively with statewide health needs; and (c) the coordination of the SHP with other state health-related agencies' plans. The Committee is comprised of 50 percent consumers and 50 percent providers. The SHPDA staff is currently preparing criteria and procedures for preparing the SHP. These will be recommended to the Committee for approval.

In summary, the State of Texas had developed a process and organization through which to develop a State Health Plan. What is not clear is whether the SHP will truly be an integration of the HSPs developed by the HSAs or whether it will be a compilation of the HSPs with a statewide health planning section added to it. Opinion is divided in the SHPDA as to which process should occur. At present, it appears that the two processes—developing HSPs and developing statewide portions of the SHP—are proceeding quite independently of one another with only a common organization and coding format to tie the two together. The crucial point will be reached as the HSPs are completed (throughout 1978) and the State Health Plan Review Committee of the SHCC attempts to develop a final SHP. Much will depend on whether the SHCC members view themselves as representatives of their HSAs or as representatives of statewide health needs or other statewide groups which they may represent. It is too early, at this writing, to tell which posture is likely to be adopted.

Oklahoma

The Oklahoma SHPDA, i.e., the Oklahoma Health Planning Commission (OHPC), has undertaken many of the same activities to develop a State Health Plan, although state health planning appears to receive less emphasis in Oklahoma than in Texas. In fact, it appears that OHPC has directed most of its attention to the regulatory and review aspects of P.L. 93-641, and has left the planning activities largely to the Oklahoma HSA (OHSA). This is probably because, as there is only one HSA in the state, both the OHSA and OHPC would be planning for the same geographic area, the entire state. An extensive, concerted planning effort on the part of both could, unless closely coordinated, lead to a substantial duplication of effort. Staff and funding limitations of the OHPC probably also limit their planning effort. The approach being used in Oklahoma appears to be that OHPC will largely use the HSP developed by OHSA as the SHP, with the addition of a section on statewide needs and state policies and programs, unless the HSP is in conflict with statewide health needs and priorities as perceived by OHPC and other state health agencies, including the Office of the Governor.

OHPC has undertaken several activities to develop a SHP. First, through the State Health Plan Development Committee of the SHCC, it issued, in September 1977, a document entitled "Guidance for Developing the State Health Plan." The guide contains a methodology and format for the SHP to guide both OHPC and OHSA in developing the HSP and PSHP. However, because it was issued well after the planning process of the OHSA had begun, its full effect will not be realized until the next planning cycle. The document generally appears to be a reiteration of the "Draft Guidelines for Developing a State Health Plan" issued by HEW in May 1977, along with an outline or format for the SHP.

A second activity of the OHPC is the publication of the "Oklahoma Interim Health Plan and Data Guide," which

reviews state health goals identified in previous planning efforts and provides baseline health planning data. The document is intended to be only an interim planning document and data source rather than a full articulation of statewide health needs, priorities, and goals. The OHPC staff also maintain continuing contact with OHSA to insure coordination of planning activities and to provide assistance to OHSA.

Third, the OHPC has instituted a process for identifying state health needs, priorities, and policies. It is conducting a survey of SHCC members, state health agencies, and statewide health related organizations to identify statewide health needs and priorities. It is also conducting a review of state laws, plans, and programs to inventory current state health policies (as required by federal guidelines). These two activities are to be the basis of the statewide health policy section which will be added to the HSP of the OHSA to form the State Health Plan.

Except to the extent that it appears willing to allow the HSP of OHSA to stand for the SHP, the approach used by OHPC in developing a SHP is not unique. What is unique are two procedural requirements placed on the final approval of the SHP which are designed to insure that state government interests are reflected in the SHP. First, a member of the Oklahoma SHCC may be removed from office for "arbitrarily or capriciously" ignoring the comments of the Governor on the SHP. Second, following *approval* of the SHP by the SHCC, the SHP does not become official state health policy until it is *adopted* by the Oklahoma Health Planning Commission.* This grant of authority to the OHPC to adopt the SHP is not envisioned in P.L. 93-641. It appears to be designed to protect the prerogatives of the three agency administrators who comprise the OHPC and whose programs will be addressed in a SHP, and to insure that statewide and state government interests are reflected in the SHP. This authority could serve to counteract the fact that 60 percent of the SHCC are also members of the OHSA Governing Board or are nominated to the SHCC by the Governing Board. This means that if the local members acted in concert, the SHCC could decide all differences between the HSP and the PSHP in favor of the HSA's HSP.

In summary, although it appears that OHPC is willing to allow OHSA to take the lead in developing the HSP which, along with a statewide needs and policy section, will comprise the State Health Plan, certain procedural steps have been taken to insure that statewide and state government interests are reflected in the SHP. How these procedures will work in practice is not clear, as the planning process has not reached the point where a SHP has been developed by the SHCC. Neither the HSP nor the PSHP has been completed at this writing.

*Executive Order of Governor David L. Boren, "Executive Order: State Health Coordinating Council," July 20, 1976.

Arkansas

Arkansas is ahead of Texas and Oklahoma in one major respect. That is, all four HSAs have completed their HSPs and had them approved by HEW. Little attempt, however, seems to have been made to integrate the HSPs into a State Health Plan at this writing. Development of the SHP seems to have awaited the completion of the HSPs, whereas Texas and Oklahoma have proceeded without them.

This is not to say that no progress has been made in developing the statewide portions of the SHP. The Arkansas SHPDA has completed or is in the process of completing most of the activities completed by the Texas and Oklahoma SHPDAs in preparing the SHP. In early 1977, the SHPDA developed a common format for the HSPs and SHP, but this format was never voted on or approved by the SHCC. As a result, the format was used by only three of the four HSAs in developing their HSPs. The SHPDA is also currently conducting a survey of state health related programs to determine state health needs, policies, and programs, and a State Health Plan Development Committee of the SHCC has been formed to advise the SHPDA on the PSHP and to integrate the HSPs into a recommended SHP. Minutes from several meetings of the State Health Plan Committee reveal some confusion about the actual SHP development process. Members are uncertain about whether they are to break down and integrate the HSPs or whether they should simply review them for inconsistencies with state needs. These Committee members have expressed a need for a common HSP/SHP format if they are to accomplish anything meaningful in developing a State Health Plan composed of the Health Systems Plans.

The SHPDA has also provided extensive technical assistance to the HSAs in developing their HSPs, including the publication of a document entitled, "Arkansas Health Manpower Resources 1977."

In summary, the Arkansas SHPDA has undertaken or is in the process of undertaking all activities leading to the development of a SHP except the actual process of integrating the four HSPs and a PSHP into a SHP. It is difficult at this point to predict how this process might actually proceed, but it appears likely that the HSPs will not be substantially altered for several reasons. There is a healthy respect within the SHPDA for the work done by the HSAs, and an attitude that the SHPDA must rely extensively on the HSAs because of limited staff and funding at the state level for significant independent planning efforts. Second, there is a desire in the SHPDA to

avoid confrontation with the HSAs and to cooperate with them to the maximum extent possible. Finally, the HSPs have previously been approved by the SHCC when they were recommended to HEW for full designation of the HSAs. These factors appear to indicate that the SHP will not differ substantially, at least in this first planning cycle, from the HSPs.

Overview

This review of the development of a State Health Plan by the SHPDAs and SHCCs in the three states yields the following observations:

- The state agencies have all begun to develop the statewide needs, priorities, and policies sections of the SHPs independently of the HSAs. This is being accomplished primarily through a survey of state health agencies and statewide health-related private organizations.
- The most extensive guidance to the HSAs on coordination of HSPs and the SHP has come in the form of a common plan organization and coding format. This format has not been approved by the SHCC in two states (Texas and Arkansas) and is not expected to affect the HSP until the next planning cycle in Oklahoma.
- All states have attempted to provide technical and data assistance to the HSAs and tried to keep abreast of HSA planning activities.
- All states have formed a committee of the SHCC to guide the development of the SHP and to make recommendations to the full SHCC on the integration and coordination of the SHP and HSPs.
- None of the states has actually attempted to integrate the HSPs and the statewide planning activities into a SHP. It is too early to tell how this process will proceed in each of the states and how it will affect the relationships between the SHPDAs and HSAs. The plans for accomplishing this integration are not clear in any of the states.

In other words, two years after the passage of P.L. 93-641, it is not yet possible to tell how one of the most crucial aspects of the Act will proceed. The three states reviewed here appear to be uncertain on how to integrate the HSPs into a SHP which will adequately address statewide health needs and still allow the HSPs to remain viable local and areawide planning documents. In fact, it is not clear that an actual integration will take place in any of the states. Rather, it appears what is adopted may well be a compilation of the HSPs with an appended section on statewide and state government needs and policies.

THE STATE MEDICAL FACILITIES PLAN

The Statutory Responsibility

Section 1603(a) of P.L. 93-641 requires that any state desiring to receive grants for the construction, modernization, or conversion of medical facilities under Title XVI of the Act submit to the Secretary of HEW for approval a State Medical Facilities Plan (SMFP). The plan should describe the type and number of medical facilities and outpatient facilities necessary to meet the health needs of the state, and the number and type of medical facilities in need of modernization or conversion in the state. The SMFP is to be based on an inventory of facilities in the state, a survey of need, and the HSPs of the HSAs; is to be approved by the SHCC "as consistent with the State Health Plan"; and is to provide a program for administering any Title XVI funds received by the state for the construction, modernization, or conversion of medical facilities.

According to draft federal guidelines,* the thrust of the SMFP is to be "cost containment," i.e., limiting the number of facilities in the state or insuring that those that do exist are used fully and appropriately. In addition to guiding the administration of Title XVI funds, the SMFP is to be used in Certificate of Need reviews, 1122 reviews, and other project reviews under the Act. The SMFP is seen as a separable part of the State Health Plan which should be developed in conjunction with the overall state health planning process.

The process of developing a SMFP is similar to that of developing an SHP in that a statewide plan is to be developed from staff work done at the SHPDA level, but is to consider recommendations contained in the HSPs of the HSAs. The SHCC is to reconcile differences and coordinate the SMFP with HSPs and the SHP. Problems of coordination are not, however, expected to be as great because the SMFP deals with a relatively narrow component of comprehensive health planning. It is also a more straight-forward, quantified type of planning and the states all have experience in facilities planning from the previous Hill-Burton facilities planning and construction program.

Activities in the States

The states reviewed in this project have all proceeded in a similar manner and to a similar point in developing a State

*Department of Health, Education and Welfare, Bureau of Health Planning and Resource Development, "Draft Guidelines for Developing a State Health Plan," May 20, 1977.

Medical Facilities Plan. Building on previous Hill-Burton facilities planning efforts, the states have updated their facilities inventories, reviewed and modified formulae for the allocation of facilities, and published Interim Medical Facilities Plans. These interim plans are designed to serve as data documents for developing HSPs and the SHP. Texas deviates somewhat from this pattern in that its interim facilities plan will be a two-volume document of which only the first, an inventory of facilities and utilization, has been published. The second volume, currently being prepared, will provide formulae for the allocation of facilities. In addition, all states use a Medical Facilities Committee of the SHCC to assist the SHPDA in developing the SMFP.

The medical facilities planning process is being delayed somewhat in all states for three reasons: (1) federal guidelines have not yet been published; (2) the HSPs are not complete in any state except Arkansas; and, (3) the State Health Plan is not complete in any of the states. Although the State Medical Facilities Plan is needed for input into Certificate of Need and 1122 reviews, this delay is not seen as crucial because no funds for grants under Title XVI have been appropriated by Congress.

No major problems have been encountered in any of the states studied here in developing the SMFPs. Interviews with Texas SHPDA officials indicate that the SHPDA is concerned, however, about the level of input it is receiving from the HSAs, which appear to give facilities planning a low priority. The experience is similar in Arkansas and Oklahoma.

Texas is also concerned about the role of the SHCC in developing the SMFP. Under Texas law, grants made under the SMFP are to be awarded by the Board of Health with the advice of the Hospital Advisory Council. These grants are, however, largely determined on the basis of statistical formulae developed by the Facilities Planning Division in conjunction with the Board of Health. The problem is in designing another advisory and approval role for the SHCC. The SHCC does have a Medical Facilities Plan Review Committee which is to review the SMFP and make recommendations to the full SHCC.

One deviation from the general pattern occurs in Oklahoma. As with the State Health Plan, the OHPC has reserved the authority to *adopt* the SMFP as a part of the SHP after it has been *approved* by the SHCC. Once again this extraordinary grant of authority appears to be designed to insure that state interests are reflected in plans approved by the local-dominated SHCC.

As with the State Health Plans in these three states, no State Medical Facilities Plans have been presented to the SHCCs for final approval.

Summary

The state agenices (SHPDAs and SHCCs) have been assigned two major planning functions under P.L. 93-641–developing a State Health Plan and developing a State Medical Facilities Plan. These plans will be the basis for most of the review and regulatory activities of the agencies. The plans have a dual role to play. They are to be reflective of statewide health needs and concerns while at the same time being reflective of locally prepared Health Systems Plans. The job of reconciling and coordinating these two health planning perspectives–state and local–is assigned to the SHCC, at least 60 percent of which, by law, must be HSA representatives. Very little guidance has been given to the SHCCs on how the reconciliation and coordination are to take place. Unfortunately, the experience to date of the states reviewed in this project also gives little indication of how this process might take place. The development of a SHP or SMFP has not reached the point in any state where the SHCC has been called on to reconcile conflicting plans from the HSAs and the SHPDAs. The manner in which the reconciliation takes place will be, in any event, a key determinant of the effectiveness of the plans and the relationships between the HSAs and the state agencies. There is some evidence to suggest that a true reconciliation and integration of the state and local plans may not take place. Rather, State Health Plans may simply be a compilation of the local plans with an added state government policy section, and State Medical Facilities Plan may be prepared primarily at the state level with little HSA involvement.

PLAN IMPLEMENTATION

One of the major changes from previous federally sponsored health planning programs contained in P.L. 93-641 is that it authorizes the health planning agencies to control, at least to an extent, the development of health facilities and services to insure their conformance to adopted plans. This control is to be exercised through the following requirements of P.L. 93-641:

- All states must enact Certificate of Need (C/N) legislation which requires that the development of certain new institutional health facilities first be approved by the SHPDA or other designated state agency. (Section 1523(a)(4)(B))
- States having entered into an agreement with the Secretary of HEW under Section 1122 of the Social Security Act, or desiring to do so, must designate the SHPDA, or another approved state agency, as the 1122 planning agency. Under

Section 1122 agreements, certain capital expenditures of health facilities which are to be reimbursed, wholly or in part, by certain federal programs must first be approved by the state 1122 planning agency. (Section 1523(a)(4)(A))
- All SHPDAs, or other approved state agencies, must periodically review the "appropriateness" of existing institutional health services and make public their findings thereon. (Section 1523 (a)(6))
- The SHCC must approve any plans or applications submitted by a state agency to the Secretary of HEW for funds for the receipt of federal health services under certain federal programs. (Section 1524(c)(6))

The purpose of these requirements is twofold: (1) to insure that health services and facilities developed in the state conform to adopted state health plans; and (2) to control the costs of health care by limiting the number of health care facilities to those deemed necessary in a comprehensive planning process, and by insuring maximum utilization of existing facilities.

As with the health planning activities described earlier, the exercise of these responsibilities by the SHPDAs and SHCCs requires coordination with the health planning activities of the HSAs. In the first three functions cited above, the HSAs are to make recommendations to the SHPDA regarding the development of new services and the appropriateness of existing services. Although the final decision rests with the SHPDA (or the agency to which the review functions have been delegated) in these areas, the state agency must provide a public, written explanation to an HSA when it disagrees with its recommendations. In the final function above, the HSAs will also be making comments and recommendations on state agency plans and, in this case, the SHCC will be the final arbiter of state and local viewpoints as it was in the development of the SHP and the SMFP.

The next section discusses and analyzes the carrying out of these four plan implementation functions in the states of Arkansas, Oklahoma, and Texas. Emphasis is placed on the actual experience to date in discharging the reponsibilities, actual or potential conflicts which could arise, and methods developed to cope with the conflicts. Certificate of Need and Section 1122 reviews (the first two items above) are discussed together because of their similarity and because they are conducted jointly in all states reviewed here except Texas, which does not participate in the 1122 program.

CERTIFICATE OF NEED AND SECTION 1122 REVIEW PROGRAMS

The Statutory Responsibility

Section 1523(a)(4) stipulates that the SHPDA of each state participating in P.L. 93-641 administer a Certificate of Need (C/N) program providing for the review and determination of need for new institutional health services prior to their development. The same section states that the SHPDA is also to serve as the designated 1122 planning agency if the state has signed an agreement with the Secretary of DHEW under Section 1122 of the Social Security Act (41 U.S.C.A. 1320a–1). Under Section 1523(b)(3) another agency of state government may be approved by the Secretary, upon request of the Governor, to carry out either of these functions, if an agreement satisfactory to the Secretary is reached by the two agencies.

The purpose of these programs is to require that, prior to their development, new institutional health services in the state be approved by an agency of the state government as being necessary and in conformance with adopted health plans. The C/N program is designed to apply to certain new services regardless of the source of funding, while the 1122 review program covers only certain new services to be reimbursed, wholly or in part, under Titles V, XVIII, and XIX of the Social Security Act (Maternal and Child Health, Medicare, and Medicaid, respectively). Under the C/N program, no new institutional health service covered by the program may be developed unless a C/N is first received. Under the 1122 program, if the state agency's decision is negative, the Secretary of DHEW may not certify a new service for reimbursement unless the Secretary decides explicitly to override the decision of the state agency. State participation in the 1122 program is voluntary. Of the states studied in this project, only Texas does not participate in the 1122 program.

A state C/N program must meet certain guidelines promulgated by the Secretary of DHEW before a SHPDA may be fully designated. These guidelines address (1) the coverage of the law; (2) the procedures to be used in reviewing applications; (3) the standards and criteria for review; and (4) the penalties for violation of the law. The regulations prescribing these minimum requirements are found in 42 *Code of Federal Regulations* Part 122, Subpart E. These are minimum requirements and may be made stricter by individual states.

1. Coverage

Under the regulations, the C/N program of a state must be applied to "all new institutional health services" proposed by a "person" through a "health care facility" or "health maintenance organization" (HMO) in the state. "Person" is defined as an individual, corporation, partnership, trust, estate, state government agency, and any political subdivision of a state, but not to include the federal government or a federal agency. "Health care facility" (HCF) is defined as a hospital, psychiatric hospital, tuberculosis hospital, skilled nursing home, kidney disease treatment facility, or intermediate care facility, but not to

include facilities of the First Christian Scientist Church, or private physicians and dentists offices whether in group or individual practice. "New institutional health services" covered by the C/N program must include:

- the construction, development, or organization of an HCF or HMO;
- an expenditure by an HCF or HMO in excess of $150,000 which must be treated as a capital expense except those solely for site acquisition, the purchase of an existing HCF or HMO, or the termination of a health service or reduction of bed capacity;
- a change in bed capacity which increases total capacity by more than ten beds or 10 percent, whichever is less; and
- health services, except home health services, which were not offered by the HCF or HMO in the previous year.

2. Procedural Requirements

The regulations prescribe a series of detailed procedural requirements which state C/N programs must meet. Those most important to this project are the following:

- Written notification of a C/N application and review must be provided to the HSA in which the service is to be located, to contiguous HSAs, to all HCFs and HMOs in the area, and to members of the public to be served by the project.
- Reviews are not, to the extent practicable, to take longer than ninety days except that HSAs must be allowed sixty days within which to make their recommendations on the C/N application.
- Written findings must be made by both the HSA and SHPDA as to the reasons for their recommendation or decision.
- A public hearing must be allowed during the course of the review upon request of the applicant, members of the public to be served, or other HCFs or HMOs in the area providing or planning to provide similar services. HSAs and SHPDAs may hold joint public hearings.
- The SHPDA must provide to the HSA a written explanation of any decision which is contrary to the recommendation of the HSA.
- The applicant or the HSA must be allowed to appeal the decision of the SHPDA, and the appeal must be heard by a state agency other than the SHPDA, as is consistent with state law governing the review of state agency decisions. An HSA may appeal the decision only if it is contrary to its recommendations.

The procedural requirements are designed to insure proper public review of the C/N applications and to place the HSA on a special basis in the C/N process. An HSA has a special status in the C/N process in that it is to be allowed to make a formal recommendation on the C/N, receive a written explanation of contrary decisions, and exercise a right of appeal equal to the applicant if the state decision is contrary to its recommendation.

3. Review Criteria

The minimum criteria to be used by the state C/N agency in reviewing applications must include:

- relationship to the health systems plan, annual implementation plan, and state health plan;
- relationship to the long range development plans of the provider proposing the new service;
- need of the population to be served by the new service;
- availability of less costly or more effective services;
- financial feasibility of the project and the probable impact of the new service on health care costs;
- relationship to the existing health care system in the area; and,
- special needs of such institutions as medical schools, HMOs, specialty centers, and biomedical and behavioral research projects.

The required review criteria are designed to insure that reviewing agencies consider a wide range of relevant factors. Primary among these seems to be the relationship to health care plans prepared under P.L. 93-641 and the impact of the proposed project on health care costs. The "National Guidelines for Health Planning" (42 C.F.R. Part 121, March 28, 1978) will also play a significant role in C/N and 1122 reviews. They contain criteria for the distribution and utilization of facilities and services and are to be included in the goals and objectives of the health plans prepared under P.L. 93-641. The National Guidelines are discussed later in this section of Chapter III.

4. Penalties

Neither the statute nor the regulations specifies sanctions which must be invoked in case of a violation of the state C/N law. The regulations simply state that penalties such as the denial or revocation of a license to operate, civil or criminal penalties, or injunction relief which the Secretary finds sufficient to insure compliance with the C/N law shall be provided.

The federal regulations governing the Section 1122 Capital Expenditure Review Program* are less detailed than those for the C/N program. Because the states reviewed here (except Texas) operate the C/N and 1122 programs together, the procedures for 1122 review generally conform to those of the state C/N program. Important differences are that the coverage of the 1122 program includes: (a) capital expenditures in excess of $100,000 (compared to $150,000 for C/N programs); and (b) any change in bed capacity (compared to increases of ten beds or 10 percent for C/N programs). Decisions made by the SHPDA under an 1122 review may be appealed to the Secretary of DHEW and

*42 Code of Federal Regulations, Part 100.

may be overturned by the Secretary. C/N decisions may be appealed only in conformance with state laws governing the review of state agency administrative rulings.

In summary, the Certificate of Need and 1122 review programs are designed to control health care costs by limiting the development of new facilities and services to those called for in adopted health plans or those which can be justified on other grounds specified in the federal regulations. In these processes, HSAs are accorded the special roles of making recommendations and being allowed the right of appeal even though the final decision is made at the state government level.

Activities in the States

Arkansas

Prior to the enactment of P.L. 93-641, the State of Arkansas did not have a C/N statute, but did participate in the Section 1122 Capital Expenditure Review Program. The 1975 Arkansas Legislature passed a C/N statute* which, in accordance with the recommendation of the Arkansas Hospital Association, contained minimal procedural detail. The Act simply directed the SHPDA, with the approval of the SHCC, to implement a C/N program which met the requirements of P.L. 93-641 and regulations issued pursuant thereto. This flexibility allowed the SHPDA to develop a C/N program which was the first in the nation to be certified by HEW as fully meeting its requirements. On July 1, 1977, the SHPDA issued its "Policies, Procedures, and Criteria for Certificate of Need Review," which integrated the major regulatory review responsibilities of the SHPDA into a single process. This document has been approved by the SHCC.

Under these procedures, Arkansas has expanded the minimum coverage required by C/N programs. The Arkansas program includes home health services, ambulatory care, and surgical centers within the coverage of the law; makes any change in bed capacity subject to review; and reduces the exempt expenditure level from $150,000 to $100,000. The SHPDA had proposed regulations which would include private physicians and dentists offices within the coverage of the law, but this was rejected by the SHCC.

The SHPDA has operated its C/N and 1122 programs for over a year and has apparently encountered no significant problems. That is to say that serious conflict has not arisen between the SHPDA and HSAs over C/N and 1122 applications. This is the case despite the fact that of the twenty applications disapproved by the SHPDA, ten were recommended for approval by the HSAs. In addition, the SHPDA approved seven other applications when the HSA had recommended that they be disapproved. None of these contrary decisions has been appealed.

Although there have been no apparent problems in the administration of the C/N program, some observers in Arkansas question the ability of the C/N and 1122 programs to effectively control health care costs either in Arkansas or in general. These doubts are based on the following concerns:

- A State Health Plan which would allow all C/N reviews to proceed on a consistent basis had not been developed.
- Arkansas is basically a rural, conservative state in which health care regulation is not viewed favorably, and in which more facilities are viewed as better health care.
- Statistical formulae which allocate health facilities and services on the basis of population, as contained in federal guidelines for health planning, do not properly account for rural health needs.
- Providers who are seen as dominating local agency decisions, are reluctant to vote against facilities and new services because they may need approval of a facility or service in the future.
- C/N and 1122 regulations do nothing to further preventive health care which is seen as the most effective cost containment measure.

In summary, the Arkansas SHPDA has implemented C/N and 1122 review programs which have been certified by HEW with relatively few problems. There have been disagreements between the SHPDA and HSAs on individual applications, but these have not produced serious conflict between the agencies. There are, however, some concerns over the ability of these programs to be entirely effective as cost containment measures.

Oklahoma

When P.L. 93-641 was passed in 1975, the State of Oklahoma did not have a comprehensive C/N law. Rather, its C/N law, passed in 1971, applied only to certain types of nursing homes* and was administered by the State Department of Health. In response to P.L. 93-641, the 1975 Oklahoma Legislature passed a C/N law to apply to health facilities other than nursing homes, to be administered by the Oklahoma Health Planning Commission.† At the same time the administration of the nursing home C/N law was transferred to the OHPC. Because the final federal regulations were not published at the time the Oklahoma

*Act No. 558 of the 1975 Arkansas Legislature

**Oklahoma Statutes*, 63 O.S. 1971, Section 1-851 et.seq.

†*Oklahoma Statutes*, 63 O.S. 1976 Supp., Section 2657 et. seq.

Legislature considered the C/N laws, they do not conform to the regulations in two areas:

- The appeals procedure under the nursing home C/N law does not conform to the federal regulations. Appeal is first to the Health Facilities Advisory Council and then to the Board of Health, both of which are part of the Department of Health, as is the OHPC. Also, the nursing home C/N law provides that only the applicant may appeal an OHPC decision; no provisions are made for HSA appeal.
- The newer C/N law does not explicitly cover all necessary health care facilities, although the rules of OHPC appear to conform to the federal requirements.

An interim committee of the Oklahoma Legislature reviewed the C/N laws and presented legislation to the 1978 session to bring them into conformance with federal requirements. This legislation passed the State Senate, but failed in the House of Representatives. Most observers agree that it failed because of concern over the outcome of an application for a C/N from Oral Roberts University then pending before the OHPC. (See discussion below.)

OHPC has adopted rules to administer the C/N and 1122 programs and has operated them since early 1977. These rules have modified the minimum federal requirements by reducing the exempt level of capital expenditure from $150,000 to $100,000 and making the law apply to any change in bed capacity. In addition to its procedural rules, OHPC has adopted two sets of supplementary criteria to guide C/N decisions. These relate to computed tomographic scanners (CT scanners) and a statewide stratified system of hospital services.

In its first six months of administering the C/N program, OHPC received 122 applications. Of these, eighty were approved, twenty-nine were declared not subject to review, eleven were withdrawn by the applicant, and two were denied a C/N.

The OHPC has encountered two major problems in administering the C/N program. First, some observers feel OHPC was not adequately prepared to handle requests for CT scanners and that the situation got "somewhat out of hand" before rules governing the allocation of scanners were adopted. Second, the OHPC has, on at least one occasion, encountered a situation in which capital equipment was purchased primarily for the use of a hospital and was to be paid for, at least in part, by hospital changes, but legal ownership resided with a private physician. OHPC wanted to review this purchase, but was advised by the State Attorney General that it did not possess sufficient legal authority to do so. The OHPC fears that this practice could become widespread as a method to evade Commission jurisduction. Proposed amendments to P.L. 93-641 would make such purchase subject to review.

The administration of the C/N program has, on at least two occasions, caused relationships between the OHPC and OHSA to be severely strained. In one instance, OHPC approved a C/N for a small nursing home after OHSA had recommended that the C/N be denied. The OHPC apparently approved the C/N because the nursing home was to be used primarily by members of a religious order which has a nationwide membership and whose national headquarters are located in Oklahoma City. It was apparently felt that the needs of the order overrode the fact that there was already a surplus of nursing home beds in the area in which it was to be located. OHSA considered appealing the OHPC decision, but felt that until its HSP was complete it did not have a firm basis for its appeal.

The other occasion concerned a Certificate of Need application from Oral Roberts University, founded by the Oral Roberts Evangelistic Association, to develop a 777-bed teaching hospital in Tulsa, Oklahoma. The University sponsors professional schools in nursing, law, theology, and dentistry, and had satisfied all requirements for medical school intent to accredit except hospital based clinical training for third and fourth year medical students. On the basis of 4.0 beds per 1,000 population (the March 28, 1978 national health planning standard), Tulsa currently has a 1,000 bed surplus. Citing the bed surplus, OHSA, in February 1978, recommended disapproval of the application. However, in April 1978, OHPC issued a Certificate of Need for 294 of the requested 777 beds. The OHPC decision was based, at least in part, on the contention of the applicant that patients would be drawn from a multi-state area rather than just the Tulsa area because of the desire of patients to participate in the religious aspects of medical care in the City of Faith Hospital.

In approving the application, the Oklahoma State Health Planning Commission found that there would be a national clientele for this hospital, for:

> . . . given their need for a hospital practicing a particular type of holistic medicine it does not appear that there is any alternative, certainly not a superior alternative for this type of inpatient service. In terms of the existing need, the proposed hospital is definitely an appropriate solution.*

The Commission went on to say that although the Tulsa Hospital Council alleged a good deal of overbedding, that several existing Tulsa hospitals "either have applications

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*Oklahoma Health Planning Commission, "In the Matter of the Application for a Certificate of Need and Section 1122 Review for the City of Faith Hospital in Tulsa, Oklahoma," Application No. 78-D-012, April 26, 1978, p. 6.

pending or indicate they intend to file applications for certificates of need to modernize beds that are outdated or out of service as substandard."* Finally, the OHPC stated that since the $55 million project would be cash financed, the savings to the patients would be substantial and the daily rate would not have to include interest payments.

The OHPC decision has been appealed to the state court system by the Tulsa Hospital Council which is asking that the decision be overturned. The Council invited OHSA to join the appeal. The OHSA Governing Board elected not to join in the appeal.

Because of the size of the proposed facility and the prominence of Dr. Roberts as a religious evangelist, the Certificate of Need was the subject of much debate in Oklahoma. The fact that the application was pending before the Commission during the legislative session is cited as the primary reason that amendments to bring the state C/N laws into conformance with federal guidelines failed. In addition, OHPC received nearly 400,000 pieces of mail on the application. One observer stated that testimony to the OHPC rarely considered ramifications of the facility for health care in Oklahoma, but concentrated instead on the political, religious, and economic aspects. The application demonstrates the potential for health regulation to affect much broader aspects of society.

The effect of the OHPC decision to issue the certificate–overturning the OHSA recommendation–on relationships between OHSA and OHPC is not known at this time. At the time of our interviews (November 1977) representatives of the OHSA, in particular, were adamant in their conviction that if OHPC overturned a negative recommendation from OHSA, it would be harmful to relations between the two agencies and the future of health p'anning in Oklahoma in general. They felt such a decision would demonstrate the effect of political influence on OHPC.

In any event, the Oklahoma HSA apparently has stronger convictions about its C/N decisions than is the case in either Arkansas or Texas. Part of this conviction is probably attributable to the fact that OHSA has responsibility for health planning and development on a statewide basis rather than on just an areawide basis. OHSA thus feels it must consider all factors which OHPC must consider and that any deviations from its recommendations are the result of "political pressure." OHSA has this conviction despite its avowed desire not to be involved too extensively in health care regulation and to leave regulation to the state. OHPC, for its part, does not feel that political pressures are the cause for its deviations from HSA recommendations, but rather that it "seeks a rationale" to support a project though it may not be justified on numerical criteria or plans alone.

*Ibid., p. 7.

As in Arkansas, there are some doubts in Oklahoma about the efficacy of C/N and 1122 as cost containment measures. These doubts reflect the following concerns:

- the ability of the OHPC to withstand political pressures and make tough decisions regarding new facilities;
- the ability of all parties to limit themselves to facilities recommended in health plans; and
- the ability of strict facilities allocation formulae to adequately address health needs in rural areas.

Texas

As stated earlier, Section 1523(b)(1) of P.L. 93-641 allows a state agency other than the SHPDA to perform certain functions upon the request of the Governor if an agreement is reached between the agencies which is satisfactory to the Secretary of HEW. Texas has exercised its prerogatives under this section to enable the Texas Health Facilities Commission (THFC) to administer its C/N program as well as conduct the appropriateness reviews to be discussed later. The Texas C/N law, passed in response to the requirements of P.L. 93-641, established THFC as the administrative agency in May 1975. The aggreement between THFC and the SHPDA provides that (a) the SHPDA and THFC will coordinate administrative responsibilities; (b) THFC shall notify the SHPDA of any rule-making procedures it undertakes; (c) the SHPDA shall provide technical assistance to THFC on request; and (d) THFC shall submit quarterly reports to the SHPDA.

THFC began administration of the C/N program in November 1975. It published interim rules in December 1975, final rules in August 1976, and is currently revising its rules to bring them into conformance with federal regulations to the degree possible within the bounds of current state law. In terms of coverage of the C/N law, THFC modified the minimum requirements of federal regulations to reduce the minimum qualifying expenditure from $150,000 to $100,000, and to include home health services within the definition of covered institutional health services.

Another provision of the Texas act which differed from federal regulations permitted a substantial number of projects to receive certificates through a grandfather effect. The Texas law states that all C/N applications filed within 120 days of passage of the Act are exempt from review, provided that development of the service began prior to February 1, 1976, and that substantial progress was made by January 1, 1977. In the first month of operation, most applications were for exemption certificates. From June 1976 through October 1976, a total of 900 applications for exemption with project costs totalling $1.3 billion were received and approved. From November 1975 through

August 1977, THFC received and reviewed 610 C/N applications with project costs totalling approximately $440 million. Of these, eighty applications were withdrawn prior to hearing, thirty-four were denied, and the remainder were approved.

In bringing the Texas C/N program into conformance with federal regulations, THFC has encountered problems in three areas:

- *Appeals Mechanisms Based on the Texas Administrative Procedures Act*
  Texas law requires that any appeal of THFC decisions be taken to the state court system and be reviewed on the "substantial evidence" rule, which requires that the court not substitute its decision for the agency's but rather determine only if the Commission's decision is based on substantial evidence. If not found to be based on substantial evidence, the case is to be remanded to THFC for reconsideration. Federal officials question whether this meets federal requirements for appeal to a separate agency whose decision is to be the final decision on the matter. Complicating this situation is the fact that federal regulations require the appeals mechanism to be "consistent with state law" and allow decisions to be remanded to the state agency for review.

- *HSA Appeals Mechanisms*
  Texas law does not specifically provide for HSAs to appeal THFC decisions which are contrary to their recommendations, but it does allow the applicant or "any party who is aggrieved" by a THFC decision to appeal the decision to the courts. Federal officials state that they are unable to determine if this clause allows the HSAs the specific right of appeal.

- *HSA Timetable to Review C/N Applications*
  Under Texas law, HSAs are allowed only forty-five days for review of C/N applications, while federal regulations specify that they must be allowed sixty days for review. THFC has tried to accommodate this by requiring applicants to provide an additional fifteen days notice to the HSAs, but this provision will need to be addressed by the Texas Legislature in its next session.

One reason federal officials have been unable to fully determine the status of HSAs to appeal THFC decisions is the legalistic nature of THFC proceedings. THFC operates the C/N program in a manner very similar to the proceedings in a court of law. Applications are heard before a hearings examiner who reports to the Commission, testimony is received from witnesses, and witnesses are subject to cross-examination by other parties. To achieve the right to appeal, an HSA must become a "formal party" to the proceedings, which generally requires retaining legal counsel and sharing in the cost of the proceedings. An HSA may submit its recommendation to the THFC as an "interested party," but such status does not allow an HSA to cross-examine witnesses or appeal a decision which is contrary to its recommendations. An HSA may appeal a THFC decision only if it is a "formal party" to the proceedings.

The legalistic nature of the THFC proceedings may make it difficult, or at least costly, for HSAs to participate fully in the process. To date, only the Houston-Galveston HSA has participated in proceedings before THFC. This HSA regularly retained counsel to act as its agent before THFC on applications within its jurisdiction for approximately ten months in 1976, but suspended this action to devote more resources to its planning functions. Other Texas HSAs have taken little part in C/N reviews. THFC regularly notifies HSAs of applications affecting them, but it receives few responses.

One striking feature of the Texas C/N program is the degree of independence with which THFC operates from other actors in the health planning arena. THFC often finds it necessary to generate its own data on which to evaluate applications. It requests data from the SHPDA and other state agencies, but has often found the data supplied to be outdated and unworkable. This independence has even been carried to the point where THFC operates only on application fees rather than on federal funds available under P.L. 93-641 in order to avoid compromising its objectivity. The application fee ranges from a minimum of $100 to a maximum of 0.35 percent of project costs or $3,500 whichever is less.

THFC's independence has led some observers to question the degree to which it will base its C/N decisions on the HSPs, SHP, and SMFP once they are developed. These observers fear that THFC will not heed the plans and instead will adhere only to its own criteria.

There is also some concern over the potential effectiveness of the C/N program because not all HSAs, particularly rural and private HSAs, desire extensive involvement in health care regulation. This is in large part due to the feeling that rural health needs require more facilities and services rather than a limitation of facilities and services.

Texas does not participate in the Section 1122 Capital Expenditure Review program at the present time. The state participated in the program for about ten months in 1973, but withdrew when the final federal regulations did not retroactively validate prior 1122 agency decisions as the Governor felt he had been assured they would.

Summary

All states reviewed in this project have implemented a Certificate of Need program, although two states–Oklahoma and Texas–still must make adjustments to conform with P.L. 93-641 and its implementing regulations. Only in Oklahoma does the program appear to have caused any conflict between the SHPDA and HSA, probably because the Oklahoma HSA seems to have pursued its C/N responsibilities more vigorously than most other HSAs reviewed. (HSAs are not required to participate in C/N reviews until their HSPs are complete and they are fully designated.) In fact, in Texas, the C/N program appears to operate quite independently of the HSAs.

SHPDA/HSA relationships in the C/N and 1122 process are less cause for concern than the potential ineffectiveness of C/N and 1122 programs as measures through which to implement plans developed under P.L. 93-641 and to control health care costs. This pessimism is based on the following factors:

- an apparent reluctance on the part of some HSAs to become involved in health care regulation;
- the ability of officials at all levels to limit themselves to adopted health plans in reviewing C/N applications and make decisions to deny additional health facilities and services;
- a perception by most people in rural areas that their health care needs require more facilities and services rather than fewer facilities and services;
- a general feeling that the most effective cost control measures lie in the area of preventive health education, a service which is not fostered in P.L. 93-641; and
- the lack of control over provider rates, hospital budgets, and the cost plus reimbursement philosophy of private insurers and the federal government.

APPROPRIATENESS REVIEWS

Section 1523(a)(6) requires each SHPDA to review periodically the appropriateness of all institutional health services being offered in the state and, after considering recommendations of the HSAs on the appropriateness of services in their jurisdictions, to make public its findings. The appropriateness review of existing services and facilities is to be performed at least every five years, and within one year after an HSA makes its recommendations. Furthermore, the recommendations are not to be made until after an HSA's HSP has been completed and adopted. If a SHPDA makes findings contrary to the goals of an HSA's HSP or AIP, it must provide the HSA with a written explanation for the deviations.

Because appropriateness reviews are not to be conducted until the HSPs are completed, and because final federal regulations were not published to govern the reviews until mid-1978, the process had not been implemented in any of the three states studied. The appropriateness review function, however, is not relished by many of the parties interviewed for several reasons:

- There is some confusion over the purpose of the review. In fact, many observers felt that the HSAs and SHPDAs would be required to close existing facilities which were found to be inappropriate.
- There is a reluctance on the part of some to become extensively involved in the regulation of health care, particularly of existing facilities.
- There is doubt that numerical criteria for the distribution of health services adequately serve the needs of rural areas.

THE NATIONAL HEALTH PLANNING GUIDELINES

States and HSAs are not left totally to their own devices in designing criteria and standards for the development and distribution of health services. Under Section 1501(a) of P.L. 93-641, the Secretary of DHEW is to issue, by regulation, guidelines for national health policy and standards for the appropriate supply, distribution, and organization of health resources which will help accomplish the purposes of the Act. The HSPs, SHPs, SMFPs, and reviews of new and existing health services are to be based on and consistent with these guidelines and standards. In promulgating these standards, the Secretary is to solicit comments from HSAs, SHPDAs, SHCCs, and other interested parties.

The Secretary of DHEW first published proposed regulations for comment on September 23, 1977.* These proposed regulations were the subject of over 55,000 comments from HSAs, SHCCs, and SHPDAs throughout Region VI and the nation. On the basis of the comments, the Secretary published revised standards on January 20, 1978, and, after another round of comments, final national health policy guidelines were published on March 28, 1978.†

The national guidelines for health planning generally establish quantitative standards, based on population or usage, for the distribution of approximately ten types of medical facilities or services. The intent of the standards is

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*42 Code of Federal Regulations, Part 121, *Federal Register*, September 23, 1977, pp. 48,502-48,505.

†42 Code of Federal Regulations, Part 121, *Federal Register*, March 28, 1978, pp. 13,040-13,050.

to control health care costs by limiting the number of new health services to those required on the basis of some quantitative criteria. In some instances, adjustments to the standards are to be allowed for unusual circumstances, such as an excessive number of elderly people in the population, excessive seasonal population fluctuations, and excessive travel time to medical services which may be required in rural areas. The need for such adjustments must be documented by the HSA. In addition, the final guidelines have a general provision allowing an HSA to make adjustments to the standards if it can justify that the standard would: (a) deny residents of the HSA access to health services; (b) significantly increase the costs of health care in the area; or (c) deny persons with special needs resulting from moral or ethical values access to health care. Such adjustments are to be reviewed by the SHPDA and must be approved by the SHCC before they can be incorporated in the SHP. The SHCC is to report to the HSA on its disposition of the request for adjustment.

The general provision allowing HSAs to make adjustments in the standards was the major change made by HEW in the proposed regulations. Most of the comments on the proposed regulations contended that national guidelines were not generally applicable to specialized local conditions and that HSAs should be allowed to modify the standards to meet local conditions, particularly in rural areas. In addition, some observers commented that the national guidelines were an attempt to control health services by the federal government rather than through local HSAs or state-level SHPDAs and SHCCs. These comments were not addressed by DHEW.

Data with which to evaluate each of the states and the HSAs studied here against each of the standards are available only for the number of hospital beds and the occupancy rate for hospitals. Those data plus the number of excess beds (over 4.0 per 1,000 population) are presented in Table 1 on a statewide basis and for each HSA in the states of Oklahoma, Texas, and Arkansas. While these data do not reflect any adjustments for elderly population, seasonal fluctuations, travel time in rural areas, or referral hospitals, there seems to be an excess of hospital beds in nearly all areas of the three states studied. In most cases, the number of beds is even above the national average of 4.4 beds per 1,000 population. In short, HSAs in these states will be hard pressed to justify new hospital beds. To meet the goals of the national health planning guidelines, they will have to play the role of regulator despite their avowed desire to avoid doing so. And the State Health Plans and Certificate of Need decisions will have to accord with these limitations.

REVIEW OF STATE AGENCY PLANS AND APPLICATIONS

Statutory Responsibility

The final plan implementation function authorized for state governments in P.L. 93-641 is contained in Section 1524(c)(6). This section requires that the SHCC review annually and approve or diapprove any plan or application submitted by a state agency to the Secretary of DHEW for the receipt of federal funds under the Public Health Service Act; the Community Mental Health Centers Act; and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. If a plan or application is disapproved by the SHCC, the Governor or state agency may request the Secretary of DHEW to review and overturn the SHCC decision and make funds available under the plan or application. The Secretary may do this provided that the SHCC is given a detailed explanation of the reasons for overturning its decision. No federal regulations have been promulgated to govern this responsibility at this writing.

The intent of this authority is to insure that proposed uses of federal funds for the development of health facilities and services are consistent with health plans developed under P.L. 93-641. The effect of this authority is to require that certain health related plans developed by state agencies, each operating under separate sets of guidelines for developing the plans, be approved by the SHCC, which is composed of state and local representatives. Conflict could arise between the SHCC (of which 60 percent of the members are representatives of local HSAs) and state health agencies who feel they are planning to meet statewide needs. As with the SHP and the SMFP, the SHCC is to be the final arbiter and reconciler of what could be different state and local perspectives on health needs. Because the SHP and HSPs are not completed and no regulations have been published, no states reviewed in this project have fully implemented this review function. It is, thus, not possible to determine the ability of the SHCC to effectively achieve this reconciliation.

Activities in the States

Despite the absence of federal regulations, the states reviewed in this project have made preparations to undertake this responsibility. The remainder of this section describes these efforts.

TABLE 1
HOSPITAL BEDS AND OCCUPANCY RATE–1976
OKLAHOMA, TEXAS, AND ARKANSAS

State/HSA	*Number of Hospital Beds*	*Hospital Beds/ 1,000 Population*	*Average Occupancy Rate (%)*	*Excess Beds*
Oklahoma				
Statewide*	13.302	4.9	63.0	2,454
Texas				
Statewide*	62.301	5.1	59.0	13.321
1. Amarillo	1,731	5.1	59.6	367
2. Lubbock	1.911	5.5	56.9	531
3. El Paso	2.314	5.2	52.3	534
4. Abilene	3.696	6.0	58.8	1.216
5. Dallas-Fort Worth	14.447	5.2	59.3	3,327
6. Central Texas*	4.702	4.0	60.6	–0–
7. Northeast Texas*	3.514	5.1	65.6	766
8. South Texas*	4.441	4.0	62.3	–0–
9. Camino Real*	5.540	4.5	56.9	660
10. Beaumont	3.405	5.8	58.9	1.053
11. Houston-Galveston*	15.508	5.8	58.3	4.602
12. Permian Basin*	1.542	4.9	53.9	294
Arkansas				
Statewide*	10,494	5.0	65.7	2,098
1. West Arkansas	3,522	5.9	64.8	1.134
2. Delta Hills*	2,179	3.9	61.4	–0–
3. Central Arkansas*	2,775	6.1	70.1	955
4. South Arkansas	2,018	4.4	65.9	183

*Studied in this Project.

Sources:

Oklahoma Health Planning Commission, *Oklahoma Interim Health Plan and Data Guide.* Oklahoma City: OHPC, 1976-77.

Texas Department of Health, Bureau of State Health Planning and Development, *Selected Health Data: Texas, 1977.* Austin: Texas Department of Health, 1977.

Arkansas Health Planning and Development Agency, Hospital Beds and Occupancy Rate, Arkansas 1976, private communication, July 27, 1978.

Oklahoma

The Oklahoma SHPDA, the OHPC, appears to have undertaken the most extensive activities in preparation for the discharge of this function. The Executive Director of the OHPC early recognized the potential conflict this authority could create and took steps to try to defuse any conflict. After the formation of the SHCC Committee on the Review of Program Proposals Administered by State Agencies, Committee members reviewed the federal requirements placed on each of the programs subject to review and met with appropriate state officials to discuss the programs. The Committee has also reviewed the Oklahoma State Drug Abuse Plan and the Oklahoma State Mental Health Plan on an advisory basis only. The opinion of the review committee has been that these two plans are well developed documents, but that the federal government requires too much redundant material. This process showed the SHCC members that these are not open-ended funding programs, but rather are programs which must meet strict federal guidelines. Each plan must be developed under separate federal regulations which place requirements on the programs of which the SHCC must be aware. The Oklahoma Health Planning Commission hopes that this process and groundwork will help avoid confrontation between state agencies and the SHCC over the administration of these programs. It is feared that if state interests are not reflected in the plans, the State Legislature may withdraw state funding for the programs requiring the HSA to raise any matching funds.

Three conditions exist which may reduce this potential conflict. First, three ex-officio SHCC members are appointed from the Public Welfare Commission, the Board of Health, and the Board of Mental Health. This will insure that the viewpoints of the relevant state departments are represented before the SHCC. Second, all SHCC members are appointed by the Governor, who can serve to instill a sense of statewide responsibility to all persons involved. Third, disapproval of state agency applications and plans may be appealed to the Operations Committee of the SHCC prior to appeal to the Secretary of DHEW.

Texas

The State of Texas has not undertaken much work to prepare itself for the exercise of this review function for several reasons: (a) the SHCC was not established until late 1977; (b) the HSPs and SHP are not complete and the PSHP has consumed most of the SHPDA staff effort; and (c) the SHPDA and SHCC are awaiting federal regulations governing the function. The SHCC has formed a committee, the Application, Budget and Project Review Committee, to discharge this function. In addition, the SHPDA is developing procedures and criteria for these reviews to recommend to the SHCC for approval. It is felt that procedures and criteria for these reviews should await the completion of the HSPs and SHP.

Arkansas

In Arkansas, the State Health Plan Committee of the SHCC is responsible for reviewing the state plans and applications of other state health related agencies as required under P.L. 93-641. The Committee has reviewed and recommended approval of the State Mental Health Plan and the State Developmental Disabilities Plan. The full SHCC approved both plans. In addition, the Committee has received an orientation to the federal programs it will be reviewing. Several times during its deliberations, the Committee has expressed an inability to fully review the plans because of the lack of a State Health Plan.

Summary

In summary, the states reviewed in this project have not yet completely implemented the SHCC's responsibility of the review and approval/disapproval of state plans and applications for federal health funds. They are awaiting the completion of SHPs and HSPs and the promulgation of federal regulations. All states are, however, undertaking certain activities preparatory to discharging this function. Generally, these activities include establishment of a SHCC committee to make recommendations to the full SHCC, orientation on the programs and development of procedures and criteria for review of the plans and applications. As in developing the SHP, the responsibilities of the SHCC will be to reconcile state and local interests and perceptions of health care needs. Unfortunately, it is once again not possible to assess the actual outcome of this process because it has not run its full course in any of the three states.

CONCLUSION

It is clear that the intent of P.L. 93-641 is to establish a two-level, integrated health planning and regulatory system in each state. The law provides for health planning and regulatory activities to be undertaken at both the areawide and state levels. It further provides that differences between the areawide and state perspectives are to be reconciled at the state level, in some instances by the SHCC and in other instances by the SHPDA.

The purpose of this chapter has been to review the plan development and plan implementation activities undertaken at the state government level in Arkansas, Oklahoma, and

Texas. It was found that each state has undertaken measures to:

- develop a state needs, policies, and programs component of the State Health Plan;
- develop an interim State Medical Facilities Plan;
- administer a Certificate of Need program for the review of new institutional health services; and
- prepare the SHCC to perform its responsibility to review and approve state agency plans and applications for federal health grant funds.

It was also found that none of the states had begun to implement the function of reviewing the appropriateness of existing institutional health services.

The chapter also attempted to make a preliminary assessment of how each of the states will proceed to integrate the areawide and state planning products into a comprehensive State Health Plan and State Medical Facilities Plan. It was found that in no state has the planning process reached the juncture where this integration will take place. It was also found, however, that there is reason to doubt that such an integration will actually take place. In each state, the state and areawide processes are operating independently of one another with no clear linkage between the two except a common plan format. In addition, in none of the states did the SHCC have a clear idea of its role in integrating the state and local planning activities.

The chapter also examined the relationships which have developed between the HSAs and state agencies in implementing the regulatory aspects (C/N, 1122) of P.L. 93-641. It was found that, despite the potential for HSA-state conflict in each decision, only in Oklahoma has such conflict arisen. Relations between OHSA and OHPC have been strained on each occasion when the OHPC has overturned an OHSA recommendation. Little conflict had arisen in Arkansas even though the SHPDA has many times overturned HSA decisions on Certificate of Need applications. In Texas, it was found that THFC operates its regulatory program quite independently of the SHPDA and the HSAs and no conflict has, as yet, developed. Finally, doubts were expressed in each state about the viability of the C/N program as an effective tool of containing health care costs and linking health planning and regulation.

CHAPTER IV

STRUCTUAL ARRANGEMENTS IN HEALTH SYSTEMS AGENCIES: THE STATUTORY REQUIREMENTS

In the National Health Planning and Resources Development Act of 1974, considerable attention was given to the structural characteristics of the Health Systems Agencies. To insure that the health planning process would be locally based and not dominated by health professionals, the law established specific criteria for health service area designations and required that governing boards have a consumer majority. Governing boards, executive committees, and standing committees of the board were also required to be "broadly representative" of the health service area, a mandate which has been translated into strict representational requirements for the membership of these bodies.

The issue of structural arrangements within HSAs has fundamental significance, both in the ability of the agencies to carry out their statutory health planning responsibilities and in their broader role of reflecting area health needs and priorities. Decisions regarding agency structure, including governing board size and selection, the use of Subarea Advisory Councils and task forces, and the use of a public or private agency framework, can have direct implications for an agency's performance as well as for its responsiveness to the people of the health service area.

This chapter focuses on the evolution and current organization of the nine Health Systems Agencies included in our study, with the purpose of identifying and examining the impact of the various structural arrangements on the health planning process. First, the statutory requirements which determine the basic framework of HSA structure will be presented and the broad issues defined. Next, the structural arrangements of each HSA will be discussed within the context of previously existing health planning bodies and their transition to the current planning system. Finally, some of the main structural issues observed in these nine agencies will be examined and some conclusions about their impacts on agency performance and responsiveness to the public will be presented.

THE STATUTORY REQUIREMENTS

The legal requirements regarding the structure and organization of Health Systems Agencies are contained in section 1512(b) and (c) of the statute. They relate to agency structure (public or private nonprofit); staff and consultants; governing body composition and organization; and the membership of advisory groups, committees of the board, and subarea councils. The specific requirements are detailed below:

Legal Structure

The legal structure of a Health Systems Agency may be:

(A) "*a nonprofit private corporation* (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health and development functions";

(B) "*a public regional planning body* if (i) it had a government board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before the date of enactment of this subsection) to carry out health planning and review functions such as those described in section 1513, and (ii) its planning area is identical to the health service area"; or

(C) "*a single unit of general local government* is the area of the jurisdiction of that unit is identical to the health service area."

"A health systems agency may not be an educational institution or operate such an institution."

Staff and Use of Consultants

(A) "A health systems agency must have a staff which provides the agency with expertise in at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii) health planning, and (iv) development and use of health resources. The function of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function."

(B) "The size of the professional staff of any health systems agency may not be less than five; except that the quotient of the population (rounded to the next highest one hundred thousand) of the

health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff must be the lesser of (i) such quotient, or (ii) twenty-five."

"If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services."

The Governing Body

A health systems agency which is a public regional planning body or unit of general local government must, in addition to any other governing body, have a governing body for health planning. The governing body of a private nonprofit health systems agency must be composed of not less than 10 members and not more than 30 members, except wherein an executive committee is formed.* Both public and private bodies are subject to representation requirements. A majority (but not more than 60 percent) of the members of the governing body and the executive committee (if any) of a health systems agency must be residents of the health service area who are consumers of health care . . . These consumers must be broadly representative of the social, economic, linguistic and racial population, geographic areas of the health service area, and major purchasers of health care.

The remainder of the members must be residents of the health service area who are providers of health care and who represent (i) physicians (particularly practicing physicians), dentists, nurses, and other health professionals; (ii) health care institutions (particularly hospitals, long-term facilities, and health maintenance organizations); (iii) health care insurers; (iv) health professional schools; and (v) the allied health professions.†

The membership of the governing body must include public elected officials and other representatives of governmental authorities, representatives of public and private agencies concerned with health, a percentage of nonmetropolitan residents equal to the percentage in the health service area at-large, and representatives of Veterans Administration hospitals and health maintenance organizations if appropriate.

The governing body of the HSA must be responsible for the agency's internal affairs including matters relating to budget, staffing, and procedures and criteria for review and comment and review and approval activities. It must also be responsible for establishment of the health systems plan and annual implementation plan, approval of grants and contracts, and comment and review and approval activities.

Advisory Groups, Committees, and Subarea Councils

If in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its membership or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation as described above.

A health systems agency may establish sub-area advisory councils representing parts of the agencies' health service area to advise the governing body of the agency on the performance of its functions. The composition of a sub-area council shall conform to the representation requirements stated above.

Within the structural arrangements dictated by the statute, health systems agencies have illustrated a variety of methods of organizing and carrying out their health planning functions. In spite of the stipulations regarding the composition of governing boards and executive committees, HSAs still exercise considerable discretion in the area of agency structure and organization.

Some of the principal issues involving the structure of Health Systems Agencies which are addressed in this chapter include private vs. public HSAs, the size of the governing board, method of selection of members of the governing board, the use of advisory groups, task forces, committees and subarea councils, and informal representation patterns.

In all of the nine cases examined, the previously existing health planning environment appears to have had a major influence on current HSA structural arrangements. In many areas, councils of governments and economic development units were already involved in health planning under the comprehensive health planning program when P.L. 93-641 was enacted. In these cases, the organization of a new unit to do health planning was generally accomplished more rapidly and smoothly. Some of these agencies were successful in maintaining their planning areas as the health service areas, thereby permitting the continuation of a public regional health planning body. In areas where there was no, or minimal, health planning being done, private nonprofit agencies were generally formed. Areas which had maintained strong centers of citizen participation in the health planning process or which had varying health needs due to geographic, ethnic, or economic conditions, generally chose to utilize subarea councils while homogeneous areas did

*The executive committee may not exceed twenty-five members and may take such action as the governing body is authorized to take except for the establishment and revision of the HSP and AIP.

†Not less than one-third of the providers of health care who are members of the governing body or executive committee shall be direct providers of health care.

not. In sum, the preexisting health planning environment has had and probably will continue to have considerable impact on the structure and organization of health systems agencies.

The structural issues identified above are addressed for each of the nine Health Systems Agencies studied in the following section.

The statute allows the designation of a regional public planning body as the Health Systems Agency only where it has been previously authorized to carry out health planning and review functions and where its planning area is identical to the health service area. Two of the HSAs included in our study are public regional planning bodies, Houston-Galveston Area Health Council and Permian Basin Health Systems Agency. There was speculation during the debate on the law that the establishment of public bodies as HSAs would make the process too political and would reduce the chances of effective decisionmaking within the agency. Conversely, the participation of local elected officials, whether through public HSAs or membership on the boards of private HSAs, were seen by many as essential to the development of public accountability and agency responsiveness.

The determination of the size of the governing board and the method of selection of its members is a matter left almost entirely to the membership of the governing body and the initial designating agency. The size is circumscribed only by the requirement of establishing an executive committee for those boards with more than thirty members. The executive committees serve the purpose of allowing more efficient operation of HSA boards, but also may tend to restrict the participation of the remaining board members. Five of the nine HSAs in our study have chosen to operate without executive committees and accordingly have governing boards of thirty members.

There is also great latitude in the method of selection of members to the governing board. The law states categories of people which must be represented on the governing board, but does not specify any particular method of selection which must be followed. As a result, a great diversity of board selection procedures has evolved. The issue of concern here is the openness of the selection process and accountability of the board members to the people of the health service area.

Another issue to be addressed is the use of advisory groups, task forces, committees, and subarea councils. As previously stated, advisory groups and subcommittees of the agency boards are not strictly bound to the representation requirements set out in the law. This flexibility in the composition requirements of advisory groups allows the HSA to utilize task forces or advisory groups rather than subarea councils which require strict conformance to the representation requirements. Subarea councils are in existence in only three of the HSAs studied, although one other HSA is seriously considering establishing subarea councils. In general, task forces, study groups, and subcommittees of the governing board have been established and represent a way for the board to delegate the data gathering and analysis functions without necessarily giving up its autonomous decisionmaking responsibilities.

ARKANSAS

Transition

The four HSAs in Arkansas supersede eight Comprehensive Health Planning Agencies (314b) which conducted health planning in their respective regions from the late sixties until the enactment of P.L. 93-641. In the two cases studied, the Central Arkansas HSA (CAHSA) has assumed the jurisdiction of a single 314(b) agency while the Delta Hills HSA comprises two former 314(b) planning areas. The Central Arkansas HSA serves the largest metropolitan statistical area in the state (including Little Rock) while the Delta Hills HSA serves a thinly populated rural area.

Central Arkansas HSA

The Central Arkansas HSA is a private, nonprofit agency. It operates on a minimal funding level of $175,000 (1977-1978) with a staff of six health professionals. All of the staff members served previously with the Central Arkansas 314(b) agency. The executive director holds the same position as he held in the former agency. No outside consultants are being used this fiscal year.

Governing Body

The agency has a governing body of forty-seven members of which twenty-four are consumers and twenty-three are providers. Seven of these are elected officials. Because the governing body is larger than thirty, it also has an executive committee of twenty-five members.

This HSA is unusual in that it has a "General Corporate Body." All citizens in the health service area are eligible for nomination and election to the governing board. Currently, the corporate body membership is approximately 700, over half of whom are employees of one hospital, St. Vincent Hospital in Little Rock.

The election of governing board members is the function of the General Corporate Body. Nominations are taken from all interest groups and from the floor at general corporate board meetings. A Nominating Committee composed of nonboard and board members monitors all nominees to ensure that the governing body is in compliance with the representation requirements of the act.

SACs, Task Forces, Advisory Committees

The Central Arkansas HSA does not have subarea councils. Its staff gave several reasons for not using SACs:

- the small size of the health service area;
- political problems which might develop between the HSA and any subarea council;
- the coordination problems which might arise between the central staff of the HSA and the staff of any SAC; and
- the operating costs for a subarea council in view of the HSA's minimal funding level.

The staff also pointed out that the General Corporate Body of the HSA is an adequate mechanism for insuring public input since its membership is open to the general public and monthly board meetings are not more than an hour's drive from most points in the health service area.

The agency utilizes a task force, the members of which are drawn from the governing and corporate bodies. The task force has already completed a study of Emergency Medical Services (EMS) and after-hours doctor care, and has presented a report to the Plan Development Committee which will make recommendations to the full governing body for final approval.

There are six standing committees with a third of their membership drawn from the general corporate body and the remaining members coming from the forty-seven-member Governing Body. The Central Arkansas HSA's bylaws stipulate that members of any standing committee or advisory body must have one-third of its members from the nonboard corporate membership. In this way, input from additional public and professional expertise is assured for the governing body decisionmaking process. The standing committees are: Nominating, Personnel, Finance, Facilities Review, Project Review, and Plan Development. All recommendations from these committees are submitted to the governing body for review and final approval.

Delta Hills HSA

The Delta Hills HSA is a private, nonprofit agency encompassing two units of regional government which formerly housed CHP agencies: the East Arkansas Planning and Development District and the White River Planning and Development District. The agency operates on a minimal budget of $212,398 (1977-1978) with six professional staff members. The executive director is the former director of the White River 314(b) agency of Arkansas. Consultants have been used to a limited degree. Their fees total $1,500 for the 1977-1978 fiscal year.

Governing Board

This agency has a governing body of fifty-five members with twenty-eight consumers and twenty-seven providers. According to the bylaws, each of the twenty-two counties must have at least one representative on the board. The remaining members are divided among the counties according to each county's percentage of the total health service area's population. Because the governing body has more than thirty members, an Executive Committee was formed. Presently, this Committee has fifteen members, but the bylaws stipulate that this number may swell to twenty-five. No county may have more than two representatives serving on this executive committee at any one time.

Delta Hills fills a vacancy on the board by sending letters requesting nominations to area (county) consumers, providers, and elected officials, as well as running a notice in a local newspaper which states both the purpose of the HSA and the date and place for a public hearing. The purpose of the public hearing is to give local citizens an opportunity to make nominations to the Board of Directors. A list of nominees is drawn from the letters and the public hearing. From this list the Nominating Committee of the board selects and recommends a person to the full board. The full board has the right to either accept or reject the nominee.

Only members of the governing body may vote on the new membership. The Nominating Committee offers counsel with respect to the representational needs of the board. Provider and consumer nominees are listed separately and voted upon separately to ensure the election of a majority of consumers.

SACs, Task Forces, Advisory Committee

Delta Hills HSA does not have Subarea Advisory Councils but there are three Technical Advisory Committees on hospitals, nursing homes and physicians. These committees are composed primarily of nonboard members. The preliminary work of the fifty-five member governing board is performed by six standing committees: Community Information and Education, Planning, Bylaws, Project Review and Facility Planning, Nominations, and Use of Federal Funds.

The staff pointed out that the county input into the nomination of governing board members ensured that the interests of the total area are represented.

OKLAHOMA

Transition

Prior to P.L. 93-641, Oklahoma had seven fully designated and funded 314(b) health planning agencies and four additional economic development districts which did not receive CHP 314(b) funds. In the early stages of the health service area designation process, it appeared that Oklahoma would be a multi-HSA state, given the number of 314(b) agencies and economic development districts (eleven overall).

The Governor, however, came out strongly for a single state HSA plan. His rationale was that only through a centralized planning and development process could comprehensive, statewide health planning take place. His stated intention was to raise the level of planning above the eleven regional districts on which state health planning was then based. This is significant since the law reads that the designation of health service areas should take account of substate planning and administrative areas as well as existing regional planning areas (Section 1511(a)(4)).

Public hearings were conducted statewide on two options: (1) the Governor's single-HSA plan, and (2) a four-HSA plan. The Regional Health Administrator, Dr. Floyd Norman, wrote in a memorandum dated May 27, 1975:

> Notwithstanding the clear feedback to the contrary, the Governor opted for the single HSA plan . . . The highly centralized concept of the Governor's proposal contradicts the intent of P.L. 93-641 which conceives the HSA as a local planning and developing body where local citizenry have a direct input into the decisionmaking process.

There was also a competing application submitted by the Health Systems Agency of Oklahoma (HSAO) to challenge that of Oklahoma Health Systems Agency (OHSA). It was finally rejected on appeal to the U.S. District Court of Western Oklahoma on the grounds that it arrived one day late at the Regional Office in Dallas, Texas. The proponents of the defeated application maintained that their organization was more representative of the State of Oklahoma than OHSA which, they argued, was controlled by the Governor. Once defeated in the courts, this group ceased to be cohesive and is no longer active.

Oklahoma HSA

The Oklahoma HSA is a private, nonprofit agency which serves the entire state. Its current budget is $1,338,040 and it employs a staff of twenty-nine professionals. The agency plans to increase its staff to forty-one professionals within a year. This is a large staff for a Health Systems Agency, but the OHSA does perform its duties for the entire state. Moreover, its use of subarea councils requires additional planners to work with and coordinate the activities of the six areawide planning bodies. Of the twenty-nine staff members, thirteen are assigned to subarea coordination and planning duties. The use of consultants is widespread.

Only a few of the professional staff members came from 314(b) agencies within Oklahoma. This is significant since there were seven funded 314(b) agencies in the state before the incorporation of this HSA. The Assistant Executive Director for Coordination was formerly the Director of the 314(b) agency of Oklahoma City. The other Assistant Executive Director for Planning and Development came from the State Health Department. Other staff persons from 314(b) agencies include the Director of Planning and a Health Planner III. In all, seven of the twenty-nine OHSA health planners and administrators were drawn from 314(b) agencies within Oklahoma.

Of the six former 314(b) directors not employed by the HSA, four are directors of planning in major hospitals in Oklahoma and Arkansas, one is the director of an HSA in Springfield, Illinois, and one is the director of a multitribal health planning program in Montana.

Governing Board

The Oklahoma HSA has a governing board of thirty members. Nominations to the governing body are presented by the six subarea councils and are screened by the Nominating Committee, which reduces the nominations to a total of eight for each open position and then submits these nominees to the Governor for his selection and appointment to the board. Each subarea council has a nominee in the final eight for each position regardless of the distribution needs of the governing body among the six SACs. Two at-large and special interest nominees (Veteran's Administration and other such interest group nominees) are also included in the final eight nominees submitted to the Governor.

The original governing body was chosen from at-large nominations made by consumer and provider groups as in preexisting CHP agencies. The Dallas Regional Office objected to the representativeness of these original appointments and transmitted its objections to the Governor. However, since no federal regulations had been published defining the "broadly representative" clause, the Governor was able to maintain the governing body as constituted.

Despite the ability of the Governor to maintain his appointments to the board, he has begun to appoint new members as vacancies arise, bringing a more diverse socio-economic/racial mix to the Oklahoma HSA Governing Body.

SACs, Task Forces, Advisory Committees

The Oklahoma HSA has elected to form six subarea councils. Two of these are located in the largest SMSAs of the state, Oklahoma City and Tulsa. The remaining four are much more rural in character. The selection of six was a compromise, since there had been eleven substate health planning areas (seven of which were 314[b] agencies), and five state health planning areas. The new SACs cut across former health planning areas.

These six SACs have drawn many former staff members from the seven 314(b) agencies. Partly as a consequence of the staff carry-over, the subarea councils have become quite competent in the compilation of health data and the identification of local health needs. Staff members of the HSA freely admit that the SACs played an important role in putting together the Health Systems Plan (HSP). With the HSP complete and most of the health planning data assembled, the role of the SACs is being downplayed by the HSA staff and its Executive Director. For example, the SACs have been denied a part in the project review process.

The governing board of each subarea council numbers thirty. Nominations and appointments to these boards are made within each SAC. Nominations come from the public at-large and from concerned health interest groups. The governing body of each council makes the final appointments subject to the composition requirements of the Act.

The Oklahoma HSA also utilizes a task force for specific *ad hoc* topics in need of investigation. This task force is established by the governing body of the HSA when it sees the need for advice on topics not already covered by its standing committees. Members of the task force are drawn from the governing body, from professional groups, and from interested area residents.

There are four standing committees. They are: Plan Development, Nomination, Project Review, and Public Education. All members are drawn from the HSA governing body, and members of the SAC boards are included on all committees except the Project Review Committee. Members of this latter committee are drawn exclusively from the HSA. Because members of the HSA governing body represent the six subarea councils, membership on the standing committees is also representative of all SACs.

Each standing committee is responsible for making recommendations to the HSA governing body concerning its topical jurisdiction. The Plan Development Committee has been the most active because of the planning focus of the HSA as a whole, though Project Review and Public Education have also been active. The recommendations of all committees are considered, amended, revised, and then voted on by the governing body of the HSA.

TEXAS

Transition

There were nineteen Councils of Government (COGs) in Texas that received funding under the Comprehensive Health Planning legislation. The two-year lag from the passage of the CHP legislation and the establishment of a 314(a) state agency precluded the state from taking full advantage of the available 314(b) funds for local agencies. Only five COGs were designated as 314(b) agencies. Most of the local planning activities in Texas were poorly funded and received only $15,000 apiece from the state agency. The latter problem can be traced to (1) the CHP law itself, which did not clearly delineate the relationship between the 314(b) agencies and the state 314(a) agencies; and (2) the lack of provider group support for the planning effort. No national goals were promulgated and insufficient responses were made to the data needs of the state agencies by the DHEW in Washington. Because of this limited preexisting health planning effort statewide, several observers felt that the rapid implementation of P.L. 93-641 in Texas had been severely hampered.

Camino Real HSA

The Camino Real HSA is a private nonprofit agency encompassing two Councils of Governments: Alamo Area COG and Middle Rio Grande Development Council. The agency operates on a budget of $644,245 (1977-78) with a professional staff of fifteen. The Executive Director was formerly the Director of the CHP (314[b])within the Alamo Area COG. Consultative fees totaled $11,750 for the 1977-78 year, and computerized data processing costs were $4,500.

Transition

The Alamo Area COG was the first areawide CHP planning agency (314[b]) designated in Texas (1969). Its accomplishments included: (1) a 1973 AACOG/CHP Objectives Plan projecting facilities and manpower needs; (2) an areawide Emergency Medical Service (EMS) plan; and (3) an AACOG Comprehensive Health Plan (completed in 1976). The Middle Rio Grande Development Council was a 314(a) subgrant agency which employed one health planner by means of a federal grant through the Governor's Office of Comprehensive Health Planning. MRGDC's Health Advisory Committee was formed in 1972 but was hindered by its meager funding, as were most other 314(a) subgrant agencies which received $15,000 apiece.

An HSA Transition Task Force consisting of six providers, six consumers, and six elected officials was set up by the Health Advisory Council of AACOG. MRGDC was represented on this task force by one provider, one consumer and one elected official. This task force established an early scheme of representation between the two COGs for the soon-to-be-created HSA governing body. Under its direction, an application was put together and submitted to the Regional Office in Dallas, Texas. No competing applications were submitted.

The initial application was rejected by the Regional Office because its governing body was not in compliance with the Act, with respect to the "broadly representative" requirement for consumer members on HSA governing bodies (see Section 1512[b][3][C]). The consumer composition was subsequently reconstituted to meet the federal requirements.

Six of the fifteen professional staff members of the Camino Real HSA were drawn from the two local COG health planning divisions, including the Executive Director, who had been Director of the former AACOG 314(b) agency. Many of those interviewed believed this overlap made the transition smoother as this accumulated expertise was not lost to the HSA as it assumed its responsibilities in planning and development.

Governing Board

This agency has settled upon a governing body of thirty members, with sixteen consumers and fourteen providers. A large board had been considered by the Transition Task Force which organized the HSA; however, though offering the possibility of a broader spectrum of representation, this proposal was dropped because:

- The need for an executive committee would reduce those not on such a committee to ceremonial duties.
- Board meetings would be more expensive because of the transportation and related costs involved.
- Reaching a quorum at meetings would be difficult, since a larger board would necessitate more rural representatives on the board. Experience had shown that such members find it difficult to attend meetings regularly.
- Costs of mailing, preparation of materials and associated costs for a large board would be prohibitive.

Consequently, a smaller board of thirty members was recommended, with the understanding that two subarea councils would be formed.

Consumer nominations are solicited from the public at-large through advertisements in the media, from major labor organizations, and from consumer groups in the area. Certain provider groups are allowed to name their own representatives directly to the governing body. Each of the two COGs in the region is allowed one direct appointment to the governing board above and beyond the open nomination process. One COG, the Alamo Area COG, screens all nominations and presents its COG Executive Committee with two names for each position. This committee then appoints the members to the HSA Governing Body, though it may override the screening committee recommendations. The other COG, the Middle Rio Grande Development Council, solicits consumer nominations in a like manner, but does not have a screening committee.

SACs, Task Forces, Advisory Committees

The Camino Real HSA has two subarea councils which correspond to the two Councils of Governments that compose the health service area. Members of the board for each SAC council are drawn from the respective health advisory committees of the COGs. This nomination and appointment process affords each COG a direct voice in the plans submitted to the HSA beyond its power to appoint members to the governing body of the HSA. Nominees are made to the SACs from health groups, physicians, and residents in the SAC area. Final appointments are made by the SAC boards.

The Regional Office of DHEW made it known that the composition of these SAC boards was not in compliance with the requirements of the Act. Rather than immediately restructuring the composition of the two SAC boards, the HSA decided to bring these boards into compliance incrementally by adjusting their composition through the annual replacement process.

Each SAC is allowed to participate in the first level of project review if the proposed project is located in its area. Their recommendations are made to the HSA governing body, but are not binding on the HSA's final decision.

Task forces are not used by Camino Real, although they were used extensively in drawing up the initial HSP. The governing body, however, does have these standing committees: Health Plan Development, Project Review, and Medical Facilities. Members of these advisory committees are drawn from the governing body of the HSA exclusively. As their names imply, they are responsible for specific topics that the HSA addresses in planning and review functions. Recommendations are made to the HSA governing body for final approval.

South Texas HSA

The South Texas HSA is a private nonprofit agency encompassing four Councils of Governments: Coastal Bend,

Golden Crescent, South Texas, and Lower Rio Grande. The HSA operates on a budget of $430,000 (1977-78) and a professional staff of nine. (There is no carry-over in the staff from the 314[b] agency in the area. However, the Executive Director, at the time of our interviews, was the former health planner for the Coastal Bend COG.) The budget includes funds for eight additional staff positions, but these have been difficult to fill because the agency is located in the small, somewhat isolated town of Kingsville. Consultant costs for auditing and legal services totalled $2,500 for the 1977-78 fiscal year.

Transition

The Lower Rio Grande COG was the only one of the four South Texas COGs to achieve 314(b) status. It was fully funded, with five staff members and three planning interns. The agency completed a Comprehensive Health Plan for its own three-county area, but was only marginally successful in overall health planning and in involving significant levels of participation from the people of the Brownsville area. Each of the other three COGs had its own health advisory or planning committees. The accomplishments of these committees were slight, and only preliminary health plans identifying health manpower needs were completed. One COG, the Golden Crescent Development Council, neither developed a health plan nor hired any health staff members.

A steering committee composed of two members from each COG was created to organize the South Texas HSA. The Director of the Lower Rio Grande 314(b) agency was an active member of this committee.

A competing application was submitted and backed by the South Texas Health Consumer Association, which felt that the COG-backed application for the South Texas HSA was biased in favor of a middle-class, Anglo approach to the area's health care needs. The consumer group's application stressed the primary care needs of the Mexican-American population. It was felt by members of the group submitting this competing application that the COG-backed application was successful because of the support it received from the Governor's Office and from other elected officials and because of the responsiveness of the Regional DHEW Office to political pressure from these officials.

In September 1977 the South Texas Health Consumers Association challenged the designation of the South Texas HSA in federal court, arguing that (1) the board did not adequately represent the income and ethnic composition of the area, and (2) Dr. Norman had acted arbitrarily and capriciously in designating the South Texas Agency when a Region VI Committee had recommended the designation of the South Texas Health Consumers Association application.

Governing Board

The governing board is composed of thirty members. Membership selection is handled through the subarea councils and through professional associations.

The four SACs in this health service area make nominations to ensure that they meet the geographic, urban/rural, linguistic, racial and socioeconomic distribution requirements of the HSA's bylaws. Providers are not required to meet any representative criteria and are nominated by the various medical and health professional associations of the area.

All nominations for the thirty-member governing body are reviewed by the Credentials Committee and final nominations are then submitted to the South Texas HSA board for approval or disapproval, and appointment. Those designated as consumers are quite responsive to their subarea council constituencies. Providers, on the other hand, are more loosely affiliated with their professional associations and report back to these organizations much less regularly than their consumer counterparts report back to the subarea councils.

SACs, Task Forces, Committees

Because of its large size and dispersed population centers, the HSA decided that a centralized Health Systems Agency was impractical. Instead, four subarea councils were established corresponding to the four COGs in the region. Each of the COGs has a distinct character with respect to the ethnic, racial, linguistic, and socioeconomic mix of the population.

Members of the separate governing bodies of each SAC are nominated from the SAC region and reviewed and voted on by the SAC board. In addition to determining its own membership, each SAC creates its own bylaws. However, both the bylaws and the final selection of SAC board members are subject to review and approval of the governing body of the HSA. A permanent staff member of the HSA is assigned to each of the four SAC offices. As well as aiding in planning through the collection of data and identifying health needs, the SACs also participate in project review. Comments are made by each SAC on projects in its area, and submitted to the HSA governing body. These recommendations are not binding on the HSA's decision.

This HSA does not use task forces, due to the substantial use of the four subarea councils in both planning and review. It does rely on standing committees to assist in the functioning of the HSA. There are five of these: Administrative, Bylaws, Credentials, Plan Development, and Project Review. Members are drawn from the governing body of

the HSA, from the SACs, and from interested citizens of the health service area. All nominations are submitted to the Credentials Committee and this body makes its recommendations to the HSA Board for approval.

Houston-Galveston HSA

The Houston-Galveston HSA is a public agency encompassing one regional council: the Houston-Galveston Area Council. The agency operates within a $1,400,000 budget and employs nineteen professionals.

Transition

The parent body of the HGHSA is the Houston-Galveston Area Council (HGAC). This council is composed of thirteen counties, including 102 local governments. It is run by a twenty-seven-member executive committee. Under the Comprehensive Health Planning Program, the Executive Committee of the HGAC performed the formal functions of the 314(b) agency. The Area Health Commission served as an advisory body to the Executive Committee during this period. A health plan was compiled in 1974.

In 1976, the same thirteen-county area served by the Houston-Galveston Area Council (HGAC) was designated as the Texas Health Service Area Number Eleven by the Governor.

As in the Comprehensive Health Planning Program, the HGAC entered into a designation agreement with DHEW as an HSA within a public regional planning body. No competing applications were submitted. The decision to apply as a public HSA under the auspices of the Houston-Galveston Area Council was made because the staff of the Area Health Commission (informally, the 314[b] agency) felt that it was to their advantage to be part of a public planning agency. In addition to increased in-house capabilities for performing its functions, the Area Health Commission (AHC) staff reasoned that being part of a body of public officials would lend its health planning activities more legitimacy and perhaps more clout.

Conditional designation was awarded to the HGAC in September 1976. The Houston-Galveston Health Systems Agency functions were granted to the Area Health Commission; once incorporated within this public body, the HGHSA was required to form a governing body of its own, separate from the Executive Committee of the HGAC. Section 1512(b)(3)(A) of P.L. 93-641 demands this, and the Regional Office made it clear that such a governing body was needed. Although the Area Health Commission had a governing board at the time, the Regional Office required changes in its composition when it approved the AHC as the conditionally designated HSA. The revisions stipulated that the governing body would include sixty-eight metropolitan and four nonmetropolitan representatives, with the inclusion of some low-income consumers. In effect, this stipulation required the governing body to reflect in exact proportion the metro/nonmetropolitan population percentages of the entire health service area.

The board is composed of seventy-one members. Each of the twenty-seven COG Executive Committee members (HGAC) appoints two Area Health Commission board members (a provider and a consumer) and the rest of the members are appointed by the Mayor of Houston and County Judges from Harris, Brazoria, and Galveston counties. These last appointments are used to maintain the proper rural-urban mix. Since all members of the Executive Commitee are elected officials, this board is constituted entirely at the initiative of elected officials.

Governing Board

Due to its large size, the HGHSA governing body must have an Executive Committee. A nineteen member Steering Committee fulfills this function and is responsible for the bulk of the formal HSA duties. Five of the original six transition Steering Committee members also serve on the HSA governing board Executive Committee.

Because the Houston-Galveston HSA is a public agency lodged within a COG (the Houston-Galveston Area Council) and sharing jurisdiction over the same service area, some rather interesting disputes have arisen. Federal law requires that a public HSA establish a governing body which is separate from the regional governing body. The existence of such a separate board, however, creates questions of authority with respect to the power of the COG vis-à-vis the HSA governing board. In the present case, the Houston-Galveston Area Council feels it had the right to enter into a contract on behalf of the HSA. The DHEW regional office disagreed. After considerable debate, the regional office ruled that the HGAC can reivew and comment on actions under study by the HSA and advise the HSA regarding these actions prior to the approval and action of the HSA, but the HSA retains final authority within its governing body.

Other conflicts have included disputes concerning the amount of overhead the COG should receive from the HSA budget and the relative importance of A-95 and the HSA reviews.

SACs, Task Forces, Advisory Committees

The HGHSA does not have any Subarea Council, though it has plans to organize approximately eleven of them. Hearings are being held throughout the health service area to determine the sites and timing of their development. This preliminary process is scheduled to be completed by

the end of the 1978 calendar year. Subarea councils might also be established by that time. The nomination and appointment process for the governing bodies of the SACs has yet to be finalized.

This HSA has three study groups and three advisory councils. Nominations for both are open to the public. Nominees are screened by the Membership Advisory Committee and approved by either the governing body or the Executive Committee. The three study groups are Health Services, Health Status, and Environmental Health. The three advisory councils are Health Planning, Chemical Abuse, and Emergency Medical Service. Membership in each includes representatives from the governing body, experts in particular topics, and interested members of the public.

The governing body has formed four standing committees in addition to the Executive Committee. Nominations and appointments are made within the board itself, since all committee members are selected from the board. Inasmuch as the nineteen member Executive Committee performs the bulk of the HSA activities, the remaining fifty-three members of the Board must rely on the standing committees for their input in the planning and review functions of the agency. The four standing committees are Membership Advisory, Plan Development, Program Development, and Project Review. The Program Development Committee is designed to include members of the subarea councils once these are in operation.

Permian Basin HSA

The Permian Basin HSA is a public HSA which is part of a single regional council: The Permian Basin Regional Planning Commission. Minimally funded with a budget of $175,000, the PBHSA employs a professional staff of five (the Executive Director was a health planner with the Regional Planning Commission before his move to the HSA), and one secretary. No consultants have been used thus far because of the lack of funds; however, $20,000 has been allocated for fiscal year 1978-79 for a consultant to assist in planning.

Transition

The Permian Basin Regional Planning Commission participated in the Comprehensive Health Planning Program, but not as a 314(b) (federally funded) agency. Rather, health planning activities were minimally funded through a $15,000 grant from the state CHP office.

The Permian Basin Regional Planning Commission (PBRPC) monitored the passage of P.L. 93-641 in Congress. Once the legislation was passed, the Planning Commission worked closely with the Regional Medical Program's Health Legislation Policy Committee (HLPC) which was responsible for developing recommendations on the implementation of the law in Texas. The initial task for the Planning Commission was to attempt to have its area designated a health service area. Because its population was below the minimum stipulated in the law (500,000), a population waiver had to be obtained in order to allow Permian Basin to operate as an independent HSA. On the recommendation of Governor Briscoe, and with the assistance of Congressman Mahon, the Secretary of DHEW, and the Health Legislation Policy Committee, Permian Basin was granted a population waiver on the basis of its low population density, large geographic area, physician shortage, demonstrated ability to perform health planning, and the recognition of the area as a *bona fide* region by other agencies.

A steering committee was appointed by the Regional Planning Commission to direct the application process and to determine whether the HSA would be a private or a public agency. The Steering Committee consisted of thirty-two members: five elected officials, five health agency representatives, seven consumers and fifteen providers. The committee soon split over the public/private issue; the consumers supported a public agency while the providers supported a private nonprofit agency. The dispute was finally resolved when the Director and the health planner of the former CHP agency (within the Regional Planning Commission) indicated that they were strongly opposed to a private agency. They preferred to keep the HSA under the auspices of the Regional Planning Commission, which would provide the health planning staff with an in-house capability. A private HSA would have precluded such an arrangement (see Section 1512[b] [1] [A]). Realizing that the newly formed HSA would not function nearly as well without access to experience and facilities of the Regional Planning Commission, the Steering Committee finally voted unanimously in favor of a public HSA for the Permian Basin health service area.

Governing Board

The thirty-member governing body of this HSA is predominantly county-based. The nominating process begins with the seventeen County Nominating Committees, composed of the County Judges with three consumers and three providers. Each of these county committees, one for each of the counties in the area, presents a slate of five consumer and five provider nominations to the Regional Nominating Committee.

The Regional Nominating Committee is composed of one representative from each of the seventeen counties. It

screens the nominations from all the county committees and then selects the nominees to serve on the governing body. These choices are made in the context of the requirements in the Act to achieve a "broadly representative" board. Once selected, the nominees are then presented to the county committees for ratification. After ratification, the nominees are appointed to the governing body by the current Permian Basin board. Replacements for open positions are appointed in a like manner, working up from the County Nominating Committees to the regional committees and back to the county committees for ratification.

SACs, Task Forces, Advisory Committees

The PBHSA does not have subarea councils. The following reasons were given for not developing SACs:

- staff and funding limitations;
- the centrally located and easily accessible HSA office does not necessitate SACs; and
- the relatively homogenous population of the HSA alleviates the need for separate forums other than the HSA governing board to ensure adequate public participation.

The agency has four task forces. All are topically oriented, and each is in the process of identifying the status of existing services in a particular area, with an accompanying narrative which describes how HSA recommendations mesh with the Health Systems Plan. Findings are to be presented to the Plan Development/Nominating Committee for review. This committee will then present its recommendations to the governing body for final approval and action. The four task forces are Physician Recruitment, Accessibility to Care, Preventative Care, and Health Science Center. Membership on each task force is composed of at least 51 percent consumers. Members are drawn from interest groups, experts in technical and health-related areas, and the general public. A staff member stated that "everyone that applied for membership on the task forces was appointed." Nominations are made to the Nominating Committee which reviews them according to representative criteria. Appointments are made by the governing body acting on the recommendations of the Nominating/Plan Development Committee.

The agency also has four standing committees. All members are representatives from the HSA board. They are nominated and appointed by the governing body to each of the standing committees. Recommendations of these committees are made to the governing body for approval and action.

The four standing committees are Nominating/Plan Development, Policy Advisory, Project Review, and Finance.

Central Texas HSA

The Central Texas HSA is a private nonprofit agency made up of four COGs: Capital Area Planning Council, Brazos Valley Development Council, Heart of Texas COG, and Central Texas COG. It operates on a budget of $473,440 (1977-78) with a staff of seven health professionals. The Executive Director formerly directed regional services for the Capital Area Planning Council. Its budget includes funds for six additional staff positions. Consulting costs for the current fiscal year are $9,650. This sum includes payments for an annual audit, legal services, accountant services, and journalism/graphics. In addition, the agency has contracted with a firm to operate an automated data system for the development and retrieval of existing data at a fee of $10,000.

Transition

Only one of the Central Texas HSA COGs, the Capital Area Planning Council, formerly received funding as a 314(b) agency. All the other COGs had health advisory councils in operation. Early in the designation process, a steering committee was formed to guide the formulation of an application for an HSA and to determine the participation level of each of the four COGs. Membership of this steering committee consisted of the chairman of each COG, the chairman of each of the COGs' Health Advisory councils or committees, the Executive Director of each COG, as well as representatives of health professions and consumers. This steering committee wrote the orignal bylaws, decided the governing body requirements for composition beyond the general requirements of the law, and established the method of selecting new members to the governing body.

To ease the inital start-up of this HSA, the 314(b) agency (CAPCO) used its close-out funds from its CHP grant in the summer of 1975 to prepare the application of CTHSA. Though the Governor's Office was slow in completing the state review of the application, Central Texas HSA was conditionally designated in November 1976 by the Regional Office.

Governing Board

The thirty-member governing body has no Executive Committee since it does not exceed the threshold calling for such a body. Nominations are made by each of the four Councils of Government in the health service area. Each COG is allowed to submit two names for every open slot on the Board and the governing body appoints the new members from these eight nominations. The appointments are governed by the requirements of the Act, as well as by

the agency bylaws, which provide for a proportionate representation of the populations of the COGs on the governing board. This form of representation is closely maintained. As a result, the Capital Area Planning Council, in which 45 percent of the health service area population resides, has many more board members than the other three COGs.

SACs, Task Forces, Advisory Committees

Though this agency originally planned on having four subarea councils to correspond to the four COGs in the area, none have yet been established. The bylaws still have a provision for SACs which indicates that the agency might develop them in the future. The staff mentioned that the delayed development of federal guidelines made it difficult to establish the board membership for SACs. They also noted that the composition requirements are still "fuzzy." The Executive Director stated that the present HSA staff would not be able to handle the extra workload if SACs were established. He emphasized time and funding constraints as the major reasons for not establishing SACs at this time.

There are currently four task forces. Nominations to these task forces are submitted by each of the current COGs and are reviewed by the staff of the HSA. Final approval and appointment is made by the governing body. The membership includes members of the governing body, experts in particular health topic areas and members of the public at-large. Task force recommendations are prepared by the HSA staff and submitted to the governing body for action. The task forces are Community and Environmental Health, Inpatient/Facilities, Outpatient/Ambulatory, and Mental Health/Mental Retardation. The six standing committees are Affirmative Action, Board Education, Board Nominations, Finance, Bylaws, and Plan Development.

Northeast Texas HSA

The Northeast Texas HSA is a private nonprofit agency. The service area includes two COGs, the East Texas COG and the Ark-Tex COG. The current budget for the NTHSA is $299,142 (1977-78) and the staff consists of eleven professionals (the Executive Director has had previous experience with a 314[b] agency outside of Texas). Consultants are not used to any significant degree, due to the relatively low funding level.

Transition

Representatives of the two COGs met to discuss the application process after the area was designated by the Governor. It was decided that efforts should be concentrated on and technical assistance given to one application. A six-member steering committee was formed consisting of two physicians (representing the two medical societies in the area), two COG representatives (one from each COG), and two hospital administrators (one from a rural and the other from a metropolitan hospital). At the present time, five of the original six members of this steering committee remain on the governing body's Executive Committee, the principal decisionmaking entity of the HSA.

Governing Board

The NTHSA has an eighty-nine member governing board. This number is the result of the provider representation requirements, as written into the bylaws. The provider membership stipulation calls for one physician provider for every fifty physicians in the area. In order to meet this requirement and to include additional provider and indirect provider representatives (hospitals, nursing homes, HMOs, insurers) the NTHSA must set aside forty-four provider positions on its governing board. In addition, and in order to meet federal requirements for consumer/provider balance, the Board must include forty-five consumer positions. Thus, the eighty-nine person board size is a direct result of the physician/provider stipulation. Because of its size, the Governing Board is steered by an Executive Committee.

According to the original bylaws, the two COGs in the health service areas were delegated the responsibility for selecting consumer members to the governing board. After the appointment of the first board, however, the bylaws were amended and the consumer nomination process is now the responsibility of the county judges in nonSMSA counties, and elected officials from the largest municipality of each SMSA county.

Consumer nominations are currently presented to the Credentials Committee of the governing board for review to ensure compliance with the requirements of the Act and the above-stated rules and regulations established in the bylaws. Provider nominations are submitted to the governing board by the various medical professional organizations; i.e., physicians and hospital groups. The final nominations for both consumers and providers are presented to the Executive Committee as a whole for its vote on new members and their subsequent appointment.

SACs, Task Forces, Advisory Committees

The NTHSA originally planned to develop subarea councils; however, this was strongly resisted by the Executive Director. He felt that SACs would compete with each other and would not be able to agree on regional priorities. Such differences would make planning for the entire area difficult. Because of these reasons, the Executive Director

stated that he preferred the topical orientation of task forces.

Originally there were five task forces. These have since been combined into a single task force. This reorganization was done in order to speed and facilitate the development of the Health System Plan (HSP). The five task forces were Health Facilities; Health Manpower Finance; Health Status/Personnel; Environmental Health; and Mental Health/ Mental Retardation, Drug Abuse and Alcoholism. Eleven members from the governing body were on each task force. The chairman of each was selected by the twenty-five member Executive Committee. The present single task force combines the membership of these five.

The only standing committee is the Credentials Committee. Members are selected and appointed by the president of the governing board and all are from the HSA board. Its primary functions are to review and make recommendations to the board regarding board composition and to advise the county judges on their nominations to fill vacancies on the HSA governing body. The advice consists primarily of suggestions concerning the representational needs of the board membership.

CONCLUSIONS

These nine HSAs constitute part of the first response at the local level to P.L. 93-641. As such, the arrangements which have been developed for local governance of the health system have in most cases been grounded in what went on before and the method by which these bodies were constituted. The principle question one may ask in examining structural arrangements is whether the hope for a local instrumentality which can perform effective health planning representing local needs may be achieved through the HSAs. The question includes issues of both representation and effectiveness and is perhaps best posed in that way. After briefly surveying the impact of the preexisting environment on the structural arrangements developed by these nine HSAs we examine the questions of representativeness more closely.

PREEXISTING ENVIRONMENT

In all the cases studied, COGs and other local planning agencies worked jointly in organizing the new health systems agencies, writing the bylaws, determining composition requirements beyond those in the Act, and deciding the nomination and appointment process for the governing bodies. The result of these efforts by local bodies in the initial organizing stage usually meant that the nomination process for governing bodies was centralized within these COGs or the SACs representing them. In all but one case, a method of proportionate representation based on the COGs in the planning area or on the counties was settled upon. The remaining agency relied upon a rather unique "general corporate body" to nominate and elect its governing body members without provisions for county or other state subdivision seats. Therefore, despite the structural framework chosen, the people who would fill out that structure would be nominated from the entities responsible for planning in the earlier period.

It was also found that the professional staff members for the new Health Systems Agencies were drawn to a large extent from preexisting planning agencies, whether COGs, regional planning councils, 314(b) agencies or 314(a) subgrant agencies. Of the nine HSAs studied, an overall average of 43 percent of the professional planning and review staff had worked with local planning agencies within the same health service area.

Some HSA staffs showed carry-over percentages as high as 80 to 100 percent. These figures suggest that health planning under the new Act did not lack planners already experienced with the local planning area. A significant carry-over of planners is healthy because of their expertise, but it should be remembered that the Act created new duties for these planners to perform. The extent to which these new powers and responsibilities will be utilized and carried out will certainly be influenced by the outlook that these planners bring with them from the other agencies.

REPRESENTATION ON HSA BOARDS

There is an attempt to provide in the Act for representation of regional, income, ethnic, rural, and provider interests. In principle, this approach will guarantee some diversity of representation of interests; but it will not mean that any board member necessarily can be held to be responsible to decide in terms that are best for the community or the general good rather than the particular groups he or she is representing. In the HSAs studied, ethnic and urban/rural proportions were adhered to and the Regional Office was active in several cases in assuring that required provider/consumer proportions on boards were met.

Regional representation was generally assured through the nomination process, with fixed numbers of seats on governing boards reserved for each county or Council of Governments based on population. With regard to delegation of functions to SACs and establishment of task forces and standing committees there was a great diversity. In no case did a governing body fail to create at least one, and in most cases several, standing committees. Of the seven HSAs with task forces, the number of such bodies ranged from one to ten, and three of the HSAs have formed SACs while one is in the process of forming them. In addition to serving as a mechanism to permit board

members to specialize somewhat and become experts in a particular area, task forces and Subarea Councils permit the inclusion of expert advice and regional representation, and potentially can serve to decentralize decisionmaking somewhat.

The reason many HSAs gave for not forming SACs was that they felt such organizations would be costly, sap the effectiveness of the overall HSA staff and potentially lead to conflict. In fact, the three HSAs with SACs (Camino Real, South Texas, and Oklahoma) were aggregations of quite heterogeneous areas, each of which required more explicit representation than the board nomination process alone would provide. Although it is too early to evaluate the effectiveness or lack of it in such bodies, the process of representation on the Subarea Councils has definitely guaranteed a voice to many rural areas that probably would not be represented explicitly on a thirty-member HSA board.

A related issue in terms of representativeness is the size of the board chosen and the requirement that all boards greater than thirty members have an executive committee. In our sample a large board seems to substitute very well for the representativeness gained through the use of SACs. Of the four HSAs with large boards and an executive committee, only Houston-Galveston even intends to establish SACs. Conversely, three of the five HSAs with boards smaller than thirty have already created SACs. With a large board, of course, the Executive Committee can become extremely powerful; but if the Executive Committee is not significantly smaller than the full board at another HSA it is not clear that this is an unsatisfactory arrangement.

Representation of providers on the boards of HSAs is an innovation of P.L. 93-641 which needs careful assessment. We found that providers were very active participants in evey HSA studied. Many providers came to board meetings with a great deal of support from their professional associations and a clear idea of how to vote on many issues. This is not improper at all in the context of the law; but it is very unusual in the context of most regulatory activity in the United States. We found very few providers and no physicians as staff members of the HSAs, and in many discussions the provider board member is the authority on the subject. One potential difficulty with this arrangement is that in many instances representatives of provider groups may be most concerned with assuring demand for the services which their groups provide. This may not be the most effective method of determining health problems and resource needs for an area.

If the HSA is just to serve as a legitimizer of federal rationing and planning directives of a fairly specific sort, the high level of provider participation will be necessary to expedite this process. If the HSA is to serve as a voice for community health needs, then several iterations and evolutions from the current arrangements will probably be required. Our research has taken place too early in the planning process to stipulate just what those changes ought to be. In many respects the diversity which we observed in the establishment of different structures for health planning at each locality may reflect the potential of the Act to spawn arrangements which can adapt to a region's needs for representation of interests and expertise.

TABLE 2
HEALTH SYSTEMS AGENCY STRUCTURAL ARRANGEMENTS, BUDGET (1977-78), AND STAFF SIZE

	Northeast Texas HSA	Oklahoma HSA	Houston Galveston HSA	Delta Hills HSA	Central Arkansas HSA
Governing Board	Private non-profit 89 members	Private non-profit 30 members	Public 72 members	Private non-profit 55 members	Private non-profit 47 members
Selection	Providers are nominated by professional assoc. Consumers nominated by county judge & officials. Appointed by HSA Governing Body on advice of Credentials Committee.	Nomination by SACs, screened by Exec. committee, appointment by Governor.	Appointed by Councils of Governments' Executive Committee. Nominating Process headed by County Judges.	Nomination publically solicited for providers, consumers, and state officials. Appointed by HSA Governing Body on advice of Nominating Committee.	Eligible for Board by attendance at 3 meetings of General Corporate Body. Membership determinted by election of the General Corporate Body and Governing Board.
Budget (77-78)	$299,142	$1,338,000	$1,400,000	$212,400	$175,000
Executive Committee	25 members	none	19 members	15 members	25 members
Standing Committee	Credentials	Plan Development Nomination Review Public Education	Membership Advisory Plan Development Program Development Project Review	Community Information & Education Planning Bylaws Project Review/ Facility Planning Nomination Use of Federal Funds Finance	Nominating Personnel Finance Facilities Review Project Review Plan Development
Task Forces	1 Task Force	Task Force	Advisory Groups: 3 study groups 3 councils	3 Task Forces	1 Task Force
Subarea Councils	none	6 SACs	11 SACs are proposed	none	none
Relationship of SACs to previous health planning areas	N/A	These 6 SACS do not conform to previous health planning areas. They all combine previous boundaries.	N/A	N/A	N/A
Size of Professional Staff	7 Professional 3 Clerical	29 Professional 11 Clerical	19 Professional 10 Clerical	6 Professional 3 Clerical	6 Professional 2 Clerical
Average Salary of Professional Staff (without Executive Director)	$16,000	$16,000	$24,070	$19,850	$14,600
(Current) Percentage of Professional staff that carry-over from previous area planning agencies (including COGs, 314(b), 314(a) subgrant, EDDs and regional planning councils)	43%	25%	?	50%	100%

TABLE 2 (continued)

	Camino Real HSA	Central Texas HSA	Permian Basin HSA	South Texas HSA
Governing Board	Private non-profit 30 members	Private non-profit 30 members	Public 30 members	Private non-profit 30 members
Selection	Nomination by COGs Appointed by the two COG governing bodies.	Nomination by COGs Appointment by HSA governing body on advice of Board Nominations Committee.	Appointment by Regional Nominating Committee, composed of members of County Committee. Selection by County Nominations Committee which is headed by the County Judge and 3 consumers and 3 providers.	Nomination by SACs and by professional assocations. Appointment by HSA governing body on advice of Credentials Committee.
Budget (FY 77-78)	$644,245	$473,440	$175,000	$430,000
Executive Committee	none	none	none	none
Standing Committees	Health Plan Development Project Review Medical Facilities	Affirmative Action Board Nominations Finance Bylaws Plan Development	Standing Committees Nominating/Plan Dev. Policy Advisory Projects Review/	Administrative Bylaws Credentials Plan Development Project Review
Task Forces	none	4 Task Forces Ambulatory/ Outpatient Community/ Env. Health Inpatient/Facilities Mental Health	10 Task Forces	none
Subarea Councils	2 SACs	none	none	4 SACs
Relationship of SACs to previous health planning areas	These SACs correspond to the 2 COGs in the area, which did previous health planning.	N/A	N/A	These 4 SACs correspond to the 4 COGs in the area. *It is noteworthy that these SACs perform the bulk of planning and review functions of HSA
Size of Professional Staff	15 Professional 6 Clerical	7 Professional 3 Clerical	5 Professional 1 Clerical	9 Professional 2 Clerical
Average Salary of Professional Staff (without Executive Director)	$15,000	$16,050	$14,700	$18,719
(Current) Percentage of Professional Staff that carry over from previous planning agencies in health service area (including COGs, 314(b) 314(a) subgrant, EDDs, and regional planning councils)	40%	43%	80%	45%

CHAPTER V

PERFORMANCE OF THE HSAs

This chapter describes and compares the functional performance of the nine Health Systems Agencies studied. The performance of these HSAs should be viewed in the context of their state agencies and their individual structures. For purposes of this report, HSA activities are categorized into two general functions: plan development and plan implementation. Each of these responsibilities are discussed in the light of our research findings. For each function, the discussion will focus on the statutory mandate of P.L. 93-641 and how, and the extent to which, the HSAs are performing the function.

PLAN DEVELOPMENT

According to P.L. 93-641, the primary planning responsibilities of an HSA are the development of a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP). This section describes the planning activities to date of the HSAs in our sample and relates these activities to their statutory responsibility.

PLANNING–THE STATUTORY RESPONSIBILITY

Under Section 1513 of P.L. 93-641, each HSA has the following responsibilities:

1) Develop and annually review a Health Systems Plan (HSP) which shall be a detailed statement of goals:

   a) describing a healthful environment and health systems in the area which, when developed, will assure the accessibility of quality health services at reasonable cost to all residents of the area;

   b) which are responsive to the unique needs and resources of the area; and

   c) which are consistent with the national guidelines for health planning policy issued by the Secretary of DHEW.

2) Develop and annually review an Annual Implementation Plan (AIP) which describes objectives which will achieve the goals of the HSP and establishes priorities among the objectives.

3) Provide technical assistance to individuals and entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP.

4) Develop specific plans and projects for achieving the objectives established in the AIP.

5) Award grants to public and nonprofit entities and enter into contracts with individuals and entities to assist them in planning and developing projects and programs, with funds for this activity made available from the Area Health Service Development Fund.

6) Solicit and facilitate community involvement in the HSA's planning activities.

PLANNING ACTIVITIES BY THE HSAs

At the time of our interviews (November 1977), five of the nine HSAs studied had finished at least a first set of plans (HSP and AIP), while four others were still in the process of developing these basic planning documents.

Arkansas HSAs

The Delta Hills and Central Arkansas HSAs, both fully designated in September 1977, submitted their plans along with their applications for full designation in August 1977. While the Central Arkansas plans conform to the uniform planning format, ultimately adopted by the Arkansas SHPDA, Delta Hills' plans attempt a more complex "systems" approach which does not conform to the format used by the other three Arkansas HSAs.

Central Arkansas HSA (CAHSA)

CAHSA's planning function is the responsibility of its Plan Development Committee which was initially formed in September 1976. Within thirteen months the HSP and AIP documents were completed and approved by the agency's Board of Directors, the Arkansas SHCC, and the DHEW Regional Office.

Several salient features characterized the CAHSA plan development process. First, persistent efforts were made to solicit the advice and concerns of health providers in the area. Separate meetings were held with hospital administrators, public health personnel, and federal categorical grantees, in which the purposes of the HSP were explained and the opinions of the attendees were sought.

Second, attempts were made to stimulate involvement in and awareness of the plan development process. Announcements were published in the area's newspapers requesting the public's views regarding the health care delivery system. Moreover, a questionnaire was developed to solicit the opinions of members of the Central Arkansas HSA's corporate body.

Third, the HSP was subjected to several reviews. In April 1976, the format, timetable, and purpose of the HSP were explained at the annual corporate meeting. The agency's Board of Directors approved one volume in May and the entire HSP in August. The document was submitted to interested parties, e.g., PSRO, SHPDA, and SHCC, and public hearings were held in three locations. Finally, after some revisions, the HSP and AIP documents were submitted to the Regional Office in August and were approved, and full designation was granted in October.

Fourth, supplementary to the HSP and AIP is a medical facility plan. The development of the plan involved a survey of long-term care facilities. The agency planned to send this document to the SHPDA where it could be used in the development of the State Medical Facilities Plan.

At the time of the field work, it did not appear that planning had a high priority at the CAHSA. The reason for this is that it has already had its HSP and AIP approved by the DHEW Regional Office, and attention has turned to the plan implementation function. Nevertheless, it has been active in two other specific planning roles. First, data sharing was taking place relatively smoothly between the HSA's facilities planner and his counterpart in the SHPDA. Second, the HSA staffers had been attempting to stimulate an Urban Health Initiative grant application for the underserved "East and Central" area of Little Rock. (The area lacks a 24-hour clinic.) Specifically, because the grant must be administered by a board separate from a hospital, the HSA had been trying to work with the Central Hospital to form an eligible board and submit a grant application.

In sum, the plan development process at the CAHSA did not encounter obstacles and thus its HSP, AIP, and medical facilities section were completed on schedule, and were sufficient to gain full designation status for the agency.

Delta Hills HSA (DHHSA)

The DHHSA received its initial conditional designation on April 16, 1976. Over the following fifteen months its first HSP and AIP were developed. On October 15, 1977, the DHEW Regional Office approved these plans and simultaneously awarded the agency full designation.

The Delta Hills Board of Directors adopted a Program/Goal/Method of Attack (PGMA) approach to planning. This approach involves three basic steps First, diagnostic conditions resulting in morbidity or mortality are identified as problems. Second, goals representing the reduction of risk among specific populations for specific diagnostic conditions are established. Finally, (a) areas of attack (e.g., system organization, lifestyle, environment, and human biology); and (b) methods of attack (e.g., preventative, curative, restorative, maintenance, rehabilitative, "live with it") appropriate to the goals and problems identified are chosen.

The process through which the first plans were developed involved several committees and substantial data collection and analysis, as well as the required Governing Board votes and public hearings. The process began with identification of twenty-two problems by the Community Health Status Sub-Committee. Next, a Physicians Technical Advisory Committee was formed, comprised of three groups of approximately five physicians each. Each group dealt with seven or eight of the twenty-two problems and developed recommended actions for each problem In a similar fashion, the advice of some Mental Health Center personnel was obtained.

Simultaneously, the agency staff collected data on health status and health care facilities. For example, questionnaires sent to nursing home administrators throughout the Delta Hills Health Service Area were analyzed and the staff produced two successive annual reports on the characteristics of residents of the area's nursing homes.

On July 28, 1977, after a public hearing attended by about 400 citizens, the HSP and AIP were approved by the Governing Board. The evening meeting, at which the plans were approved, was attended by approximately 250 people. The plans were then submitted to the DHEW Regional Office, along with the applications of Delta Hills and the other Arkansas HSAs for full designation.

Our interviews took place about a month after full designation was obtained. At that time, the agency planned to revise the AIP and HSP, with first drafts to be finished in the spring, public hearings to be held in the summer, and final plans to be submitted to DHEW and the Arkansas SHCC and SHPDA in late summer of 1978. Finally, in addition to updating the plan, the HSA intends to develop mechanisms through which it could assess progress toward achieving the goals stated in the HSP and AIP. Thus, the agency's "Work Program Design" for FY 1977-78 includes plans for the establishment of a consumer-majority Evaluation Committee, development of evaluation criteria, and publication of evaluation reports.

In sum, Arkansas HSAs have taken significant steps in

fulfillment of the planning function. All are fully designated and have completed HSPs and AIPs.

Texas HSAs

Camino Real HSA

The Camino Real HSA prepared its preliminary HSP in March 1977. Public hearings on the draft HSP were held in April, and a final draft, which included some minor changes resulting from comments made at the public hearing, was adopted in May. Some largely technical revisions were made after that in order to maintain consistency with the AIP as it was developed. The HSP was then submitted to DHEW's Regional Office in December 1977, along with Camino Real's application for full designation.

Camino Real's HSP development was facilitated by the extensive health planning that had been carried out by one of its predecessors, the Alamo Area Council of Governments (AACOG). In fact, much of the HSA's HSP is based upon the AACOG's Comprehensive Health Plan of 1976. This latter plan had been reviewed in 1975 by consumers at eight "community involvement" workshops throughout the AACOG region.

However, since the Camino Real Health Service Area encompasses the Middle Rio Grande Development Council (MRGDC) as well as the AACOG area, the HSA had to expand the coverage of the plans. To accomplish this task, once the HSA had been organized and had assumed the health planning functions of the AACOG and the MRGDC, a community meeting was held in Del Rio in order to ascertain the MRGDC region's health needs and to incorporate these needs into the HSP.

The AIP was drawn up during 1977 by the Health Plan Development Committee (HPDC) with the aid of twenty-two task forces. These task forces, which were largely composed of providers, were established in order to acquire expert advice and information quickly. However, their reports were reviewed by the HPDC, in which consumers were a majority.

Some dissatisfaction with the providers' heavy involvement in the AIP development process arose within the Committee. There was a feeling that cost control objectives, which are of great importance, had been downgraded or ignored. This lingering dissatisfaction led to an attempt in November to scrap the HSP and AIP drafts and begin the whole process again. Although this motion was defeated, the vote in favor was larger than most expected.

The South Texas Health Consumers Association (STHCA) had protested that the plan development process involved very little effort by the HSA to gain input from the poor and Mexican-Americans in the area. The STHCA held its own meeting in Crystal City to draw up a list or priorities for that area. This list was then submitted to the HSA. The HSA's Executive Director charged that the Crystal City meeting was little more than a rubber stamp of priorities already drawn up by STHCA, and that all but three of those priorities were already included in the HSP. STHCA supporters replied that some of their priorities may have been included within broad goals of the HSP but that the true substance of their needs was not reflected there.

On February 3, 1978, DHEW officials in Dallas announced that Camino Real's application had been deferred, but the HSA could reapply in six months. In the meantime, Camino Real would operate at its current funding level. Dr. C.F. Hamilton, director of DHEW's Office of Regional Health Planning in Dallas, said the HSA needed to rework its criteria for Certificate of Need review, clarify its method of handling data for the HSP, and revise its AIP. One specific suggestion was that Camino Real's AIP and HSP should be "put into a more easily read document for community use." After initially considering an appeal of DHEW's action, the HSA began working with regional office officials and other local groups to meet their objections.

Houston-Galveston Area Health Commission (HGAHC)

The Houston-Galveston Area Health Commission (HGAHC) is the fourth HSA in our sample that has already prepared at least one set of HSP/AIP documents. However, its initial HSP/AIP documents were rejected by the Regional Office of DHEW. Some of DHEW's reasons for this rejection were that the objectives were not quantified, health status was defined too broadly, health needs were not discussed fully, a linkage between the AIP and HSP was lacking, the AIP was too narrow in addressing only the subject of Emergency Medical Services, and the plans did not follow the statewide common format.

On the assumption that time, data and staff shortages precluded the development of comprehensive plans, the HGAHC chose to concentrate its AIP efforts on emergency medical services, for which it had already developed a plan. Staffers reasoned that the problems involved in emergency medical services represented a microcosm of the area's health system, and thus, the complete development of a plan for one functional area would provide a model for future, more comprehensive planning.

Since the rejection of their initial plan in July 1977, the HGAHC has undertaken a new process of plan development. It hopes to have a new set of plans prepared by September 1978, and will apply for full designation at that time.

In developing its new HSP, the agency has moved on a number of fronts. First, a plan development committee, study groups, and task forces have been developed to look into various areas of concern. These committees have all met the representation requirements, although they have

been assisted by technical experts and their meetings have not always been well attended by consumers. The staff has tried to develop data relating to health status in the area. Thirty-four public meetings were held between December 1977 and February 1978 to get community input into areawide needs. Some of these were well attended, others were not. The final plan contains a list of area goals and includes alternative ways of implementing these goals. The AIP development will be left to the SACs to determine how each area will implement the goals.

In addition, the HSA hopes to develop data and recommendations for the Texas Medical Facilities Plan and develop a plan for the use of Area Health Service Development Funds.

In sum, the Houston-Galveston Area Health Commission seems to have reformulated its procedures and intentions in order to satisfy the desires of the DHEW Regional Office. Not only does the HSA intend to develop a more comprehensive HSP/AIP, but it also indicated that it intends to go as far as the development of a plan for the use of as yet nonexistent AHSDF monies. Finally, efforts are planned to solicit community involvement and to develop Subarea Advisory Councils in order to institutionalize such involvement.

Permian Basin HSA (PBHSA)

A fifth and final HSA that has completed its initial planning effort is the Permian Basin HSA in West Texas. After some initial controversy over whether the HSA would be a private or public entity, and after an initial disagreement with the DHEW Regional Office, the PBHSA was conditionally designated as a public nonprofit agency on May 14, 1976

By January of 1977 the agency had developed its HSP and AIP. But in May the PBHSA's application for full designation was denied by DHEW on the grounds that its plan development methodology and its HSP/AIP documents were inadequate. In the view of the PBHSA staff and board members, their application was adequate but refused because of the lack of federal regulations and the state and federal officials' lack of experience with the new process. PBHSA's application was the first to be considered by the DHEW Regional Office, and consequently, the HSA staff members feel their request for hearings and a reconsideration did not receive an adequate response.

In developing their first set of HSP and AIP documents, the HSA used the following process. First, it held a Governing Board meeting in order to "brainstorm" the area's major health concerns. Twenty-one major concerns were listed. Second, it held a series of meetings in November and December of 1976 with the area's professional associations on the technical aspects of these twenty-one concerns. The Governing Board accepted the professionals' suggestions with minor revisions. Third, the staff and a consultant from Houston drafted the HSP and AIP which were approved by the Governing Board in January 1977. Little assistance was received from the Regional Office or the Texas SHPDA.

Fourth and finally, public hearings on the plans were held in each of the area's seventeen counties. Approximately 200 people participated in these hearings and a few revisions were made in the HSP as a result of community comments and input.

As mentioned above, the agency's initial plans were rejected along with the HSA's application for full designation. At the time of the interviews, the HSA was in its second year of conditional designation and was working with a new planning process, attempting to revise its first HSP and AIP. A completed set of planning documents was anticipated for January 1978.

The new process differs from the first year process in several respects First, the Nominating Committee assumed responsibility for directing the planning effort, becoming the Plan Development/Nominating Committee. Second, four overall components of the Plan were identified and isolated for study by this Committee These four were (1) physician recruitment, (2) accessibility of care, (3) preventive care, and (4) a health science center. Further, there were ten additional components of the plan. They are alcoholism, drug abuse, and mental health/mental retardation; emergency medical services; rehabilitation; heart disease; environmental health; cancer; renal disease; communicable disease; dental health; and maternal, prenatal, child, and adolescent health.

These ten components were delegated to task forces consisting of ten to twenty residents (51 percent consumers, 49 percent providers). Technical experts, "knowledgeable" members of the general public, and respresentatives of affected groups are members. According to a staff person, "everyone who applied to serve on the task forces was appointed." In general, however, task force members were recruited through the Governing Board, task force chairpersons, and professional and other health-related groups.

A series of at least three meetings were held by the task forces to identify a status and systems narrative of existing services in the area, to develop goals and objectives, and to reommend actions and resource requirements to meet the health concerns identified earlier. The general consensus among the staff and Governing Board members is that the task forces provide a mechanism for substantive local input. The task forces' recommendations were to be aggregated by the Plan Development/Nominating Committee and then submitted for the approval of the Governing Board.

Fourth and finally, the second year planning process

differs from the first year's because consultants are no longer being used. Some sentiment was expressed that the use of a consultant by the HSA in the first year's planning process may have "circumvented . . . local input." Instead, the new task force process appears to rely upon the technical and consumer advice of the area's residents and thus may induce more community involvement and produce plans that are responsive to local needs.

In addition to its activities in developing an HSP and AIP, the PBHSA has identified specific projects to be financed through the currently unappropriated Area Health Services Development Fund. Specific projects and plans were to be included in the AIP, which was to be completed in January 1978. The HSA also has produced a resource development document applicable to the grant administration function. Nevertheless, despite these preliminary planning efforts, no additional work has been undertaken in these areas since the developmental (AHSDF) monies are not yet appropriated nor are they expected soon.

Thus far we have examined five HSAs that have already presented HSP/AIP documents and, at the time of the interviews, were busy writing new plans and reworking their planning processes. The remaining four HSAs in our sample had not completed their first planning documents at the time of the research.

The discussion now turns to the planning activities of these four remaining HSAs: South Texas, Central Texas, Northeast Texas, and Oklahoma.

South Texas HSA (STHSA)

The STHSA is a private agency covering an area heavily populated by Mexican-Americans. It covers a large area, encompassing four Councils of Governments. One of the COGs was a CHP (314[b]) agency prior to the designation of the South Texas Health Service Area.

At the time of the research, the STHSA was busy attempting to produce its HSP/AIP documents by the spring of 1978. The STHSA's approach has been unique among the nine HSAs studied in that it has encouraged each of its four Subarea Councils to prepare its own health systems plan. These plans were submitted to the HSA in November 1977.

Staff members anticipate that conflicts will emerge when the HSA attempts to produce an HSP/AIP that reconciles the specific local needs, as expressed in the SAC plans, with the regional needs of the South Texas health service area. The SACs have put a great deal of effort into developing their plans, and thus, it is expected that each will be reluctant to see its proposed goals and specific projects overturned or replaced by the HSA. Yet, this conflict is inherent in a process that attempts to institutionalize the aggregation and reconciliation of differing interests. This conflict is similar to that expected when states with multiple HSAs, e.g., Arkansas and Texas, attempt the aggregation of the HSPs into a single State Health Plan.

Jurisdictional conflict might also be anticipated between the STHSA and its SACs as a result of bureaucratic territorialism. Each (that is, the HSA and the SACs) might seek to increase its functional responsibilities, funding, autonomy, staff size, and influence in decisionmaking. Nevertheless, it is clear in P.L. 93-641 that HSAs have a recognized legal status whereas SACs exist in a position subordinate to HSAs.

In conclusion, the planning experience of the STHSA thus far evidences the problems involved in reconciling interests at different levels of governance. In order to stimulate community involvement and to insure HSA responsiveness to subarea needs, the STHSA allocated major planning responsibilities to the SACs. On the one hand, community involvement levels may have been increased. On the other, it is possible that subsequent regional planning may be hindered by conflicts between the HSA and its SACs, and among the SACs.

Northeast Texas HSA (NETHSA)

The NETHSA was conditionally designated on August 14, 1976. Since that original designation, the HSA has been busy with organization and plan preparation. Second year conditional designation was awarded in August 1977.

In 1976, five topical task forces were established to inaugurate the development of an HSA/AIP. The agency originally considered developing Subarea Councils, but did not adopt them. It was felt that SACs were inappropriate for health planning because they might compete with each other and be unable to agree on regional priorities.

Originally, each task force consisted of eleven members, all drawn from the eighty-nine member Governing Board. Chairpersons were selected by the Executive Committee. Although participation varied on each of the task forces, the fact that Governing Board members were placed on the task forces provided an important avenue for the involvement of Board members who were not also members of the Executive Committee.

Of all the task forces, the task force on environmental health probably achieved the most involvement of its members. This is attributed to the fact that on this task force all members began with similar levels of knowledge about the subject, and thus, there was not a natural advantage for providers vis-à-vis consumers.

The five task forces were consolidated into one on August 23, 1977, by action of the Executive Committee. Apparently, this was done in order to hasten the development of the HSP/AIP documents. Since its first meeting in September, this forty-member joint task force has adopted

the Texas SHPDA's HSP format and reviewed drafts of the Health Status Assessment developed earlier by the Health Status task force.

The NETHSA's planning process has been slow partly because of the numerous disruptions and problems it has encountered. One problem mentioned was the lack of adequate data. Although the HSA obtains data from several sources, those data are generally irrelevant to the concerns to be raised in the HSP. One staff member commented that sometimes it was necessary to rely on personal contacts to obtain relevant data.

The HSA's planning activities have also been disrupted by external events. The September "National Guidelines for Health Planning" (CFR 42, No. 185, September 23, 1977) caused considerable delay in the agency's plan development activities. Opposition to the guidelines was such that a resolution was passed at an Executive Committee meeting on November 29, 1977, protesting the guidelines' removal of local control, rigid formulas, and disregard for rural health needs.

At the time of our visit, the NETHSA joint task force was scheduled to meet in January 1978 in order to develop goals and objectives for the HSP. Thinking ahead to the formulation of a final HSP/AIP, some staff members expressed concern that they would encounter difficulties in (1) determining reasonable goals and objectives; and (2) presenting information in the HSP in a manner that would be comprehensible to the general public. The HSA hopes to have its planning documents published and ready for submission along with its application to DHEW for redesignation by August 1978. However, it is possible that the agency will request an extension of its conditionally designated status into a third year.

Central Texas HSA (CTHSA)

CTHSA was conditionally designated on November 22, 1976. The Executive Director was appointed at the end of that month, and the staff was hired by March 1977. In February 1978, the agency's first HSP and AIP were presented to the public.

Planning at this HSA had a slow beginning. The agency's application for conditional redesignation was initially rejected by the DHEW Regional Office. Only after resubmission of the application was second year conditional status received (September 1977). One major conflict with the Regional Office seems to have stalled CTHSA's early planning work. This involved a difference of opinion over the HSA's proposed use of computers for data analysis. While the Regional Office stood steadfastly in opposition to it, the CTHSA staff, especially the Executive Director, struggled long and hard, albeit unsuccessfully, to get funds for its proposed sophisticated, computerized data analysis.

In August 1977, nine months after receiving its original conditional designation, CTHSA created four task forces as aids to its plan development function. Also, the Governing Board adopted the State HSP format as the format of its own HSP. The task forces were made up of Board members, professional experts, and consumers. Unlike the NETHSA, which chose all task force members from its Governing Board, the CTHSA task force members are selected from a wider array of people.

After their creation, these task forces worked on drafting proposals for long-term and short-term plans. The first drafts met mixed reactions. While some people were satisfied with the plans, others had complaints. First, one staff member noted that the recommendations were too idealistic and impossible to achieve. Second, some task force members complained that the data provided by the staff were not helpful. It was mentioned that the data were generally old and were presented in formats which were difficult for laypersons to understand. Third, one task force member claimed that a staff member had written Task Force recommendations in a manner contrary to the wishes and decisions of the Task Force. It was alleged that some recommendations were added, excluded, or changed.

Further, a task force member accused the Chairperson of the Governing Board and the entire Board of (1) being dominated by providers, and (2) stifling consumer influence by using task forces dominated by providers. Finally, the staff of the task force was accused by a task force member of writing some objectives in a racially insensitive fashion.

In sum, then, the CTHSA experienced a long delay in initiating the planning process, which was further slowed as a result of the HSA's request for funds for computerized data analysis and the DHEW Regional Office's refusal to approve such a request. In time, that point of conflict was resolved, and the HSA organized for planning by developing task forces. At the time of writing, the HSA was in the process of preparing an application for full designation to be submitted to DHEW's Regional Office in the summer of 1978.

Oklahoma HSA (OHSA)

As seen in previous chapters, Oklahoma has a single statewide HSA. Six Subarea Advisory Councils serve to articulate substate health concerns. The OHSA initially received conditional designation in April 1976. The planning function is carried out by a Plan Development Committee. At the time of the interviews, this committee and the HSA in general were rushing to finish the HSP/AIP documents by the spring of 1978, as it hoped to receive full designation at that time. The publication and acceptance by DHEW of these plans became a major concern of the OHSA when it became apparent that the impact of its review and

comment, and especially, review and approval/disapproval activities, would be enhanced by its achievement of fully designated status. (In order to receive fully designated status, an HSA must have prior or simultaneous approval of its HSP/AIP.)

OHSA's planning process involves activities by the HSA itself and its six SACs. Throughout its early development, the HSA has allowed—in fact, requested—the SACs to play a large role in planning, including activities such as (1) the identification of local health needs and resources, (2) the formulation of recommendations regarding their areas' health service plans and projects, and (3) the collection of health data. The HSA's planning roles have involved the aggregation and articulation of these data and recommendations provided by the SACs.

Nevertheless, it should not be inferred that the HSA has been a mere pass-through for SAC planning suggestions. Because all statutory authority rests with the HSA, and none with the SACs, and because it is possible that the needs and recommendations of the SACs will conflict with one another, the HSA has independent authority over the content of the HSP and AIP. In fact, it became clear during the research that most parties associated with the HSA, the Oklahoma Health Planning Commission (Oklahoma's SHPDA), and the DHEW Regional Office favored a diminished role for the SACs in future planning and reviewing activities. In this view, now that the local data have been collected and needs identified by the SACs, future planning will require less SAC involvement and far more central direction from the HSA.

PLAN DEVELOPMENT: SUMMARY

The performance of the plan development function by the HSAs in our sample has varied. Comparisons at the state level yield several conclusions. First, of the three states, Arkansas has made the most progress. In October 1977, all four Arkansas HSAs received full designation status and had their HSPs and AIPs accepted by DHEW. The Arkansas SHPDA had developed a common HSP format which was subsequently adopted by three of the four HSAs. The Delta Hills HSA, however, used an alternate format called a Program/Goal/Method of Attack (PGMA) approach.

The Delta Hills and Central Arkansas HSAs were attempting to gather and generate data on which they could update and improve their plans. For example, the Central Arkansas HSA's facilities planner was sharing data with the SHPDA, and the Delta Hills HSA conducted a mail survey of the area's nursing homes in order to determine resident characteristics.

Oklahoma's planning process has been a joint effort of the HSA and its six Subarea Advisory Councils. An HSP and AIP were not completed at the time of the interviews in November 1977. However, they were anticipated for the spring of 1978. Planning efforts of the OHSA have intensified as it has become apparent to its members that the HSA's powers vis-à-vis the OHPC and the SACs regarding the proposed City of Faith Hospital in Tulsa are limited as long as the HSA is not fully designated and does not have an HSP and AIP accepted by DHEW.

Finally, the planning efforts of the six Texas HSAs in our sample have encountered several obstacles. Several of the HSAs have had their initial plans rejected by the Regional Office of DHEW. Permian Basin's plans, the first to be considered by the Regional Office, were rejected in May 1977. Also, Houston-Galveston HSA's initial plans, using emergency medical services as a "microcosm" of the area's health system, were rejected in July of that year. Similarly, the Central Texas HSA's application for conditional redesignation for its second year was rejected initially and accepted only after revision and resubmission. Finally, more recently, the Camino Real HSA has had its application for full designation deferred for six months by the Regional Office.

The remaining Texas HSAs, the Northeast Texas and South Texas HSAs, have not produced their first plan documents. The initial planning processes were in full swing at the time of our interviews and completion was expected shortly. The Northeast Texas HSA has had delays in organizing, and the furor over the National Health Planning Guidelines has caused further delays, while the South Texas process has been complicated by the heavy involvement of its four SACs in the plan development process.

PLAN IMPLEMENTATION

Under P.L. 93-641, Health Systems Agenices are given some responsibilities for controlling the future development of the health systems in their areas. Most of these control functions involve the review of proposed health services or the promotion of new services. HSA activities in the implementation of these control functions are to be carried out in a manner consistent with their respective Health Systems Plans and Annual Implementation Plans. In other words, HSAs have a dual function: planning *per se* and implementation of the prepared plans. Implementation, either in the form of restricting or of enabling the expansion of health services, links the regulatory aspects of P.L. 93-641 to its planning aspects. In theory, this linkage is made through the HSPs and AIPs, since it is those plans that indicate which health services are necessary (and thus which should be restricted). Discussed below are the HSAs' plan implementation functions in terms of the dual roles of restricting and encouraging health services.

TABLE 3
PLAN DEVELOPMENT AT NINE HEALTH SYSTEMS AGENCIES

	Central Arkansas	Delta Hills	Camino Real	Houston-Galveston	Permian Basin
First HSP/AIP	Accepted by Regional Office (Oct. 1977).	Accepted by Regional Office (Oct. 1977).	Preliminary HSP (March HSP/AIP (Feb. 1978)	Initial plans rejected (July 1977). New plans submitted Sept. 1978.	Rejected, May 1977. New plans expected Jan. 1978.
Status	Fully designated (Oct. 1977)	Fully designated (Oct. 1977)	Application for full designation status deferred (Feb. 1978).	Application for full designation expected in Sept. 1978.	Application for full designation rejected (May 1977); second year conditionally designated.
Salient Features	(a) used SHPDA format	(a) used PGMA* approach	(a) activist consumer group (STHCA)† opposes the plans.	(a) initial plans addressed EMS as "microcosm" of area's health system.	
	(b) smooth process	(b) relatively smooth process		(b) developing SACs	

	South Texas	Central Texas	Northeast Texas	Oklahoma
First HSP/AIP	In process (expected spring 1978)	Presented to public (Feb. 1978)	(expected Aug. 1978)	(expected spring 1978)
Status	Conditionally Designated	Conditionally Designated. Will apply for full designation (summer 1978).	Second year conditional designation (Aug. 1977) Will apply for full designation or request 3rd year conditional designation (Aug. 1978).	Second year conditional Designation (April 1977) Will apply for full designation in spring/summer 1978 with completion of HSP/AIP.
Salient Features	(a) SACs prepared their own plans (Nov. 1977)	(a) adopted SHPDAs format	(a) adopted SHPDAs format	(a) joint effort of OHSA and SACs; SACs took lead in identification of health needs.
	(b) Difficulty expected in aggregating plans of 4 SACs.	(b) some tension in task forces and committees.	(b) Planning process disrupted several times.	(b) Role of SACs to be reduced in future planning. Denied role in project review by HSA.

*Program/Goal/Method of Attack
†South Texas Health Consumer Association

RESTRICTING HEALTH SERVICES: THE STATUTORY RESPONSIBILITY

P.L. 93-641 confers upon HSAs a responsibility for restricting proposed or new health services to those deemed necessary by the HSPs and AIPs. Section 1513 empowers HSAs to:

(1) review and approve or disapprove each proposed use within its health service area of Federal funds

(i) appropriated under [P.L. 93-641], the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion or support of health resources or

(ii) made available by the state in which the health service area is located (from an allotment to the State under an Act referred to in clause (i) for grants or contracts for the development, expansion, or support of health resources. [Elsewhere in this report these reviews are referred to as reviews and approvals/disapprovals of the uses of federal funds.]

(2) review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency. [These reviews are referred to elsewhere in this report as Certificate of Need and 1122 reviews.]

(3) review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and . . . make recommendations to the State health planning and development agency . . . respecting the appropriateness in the area of such services. [These reviews are referred to elsewhere in this report as appropriateness reviews.]

RESTRICTING HEALTH SERVICES: ACTIVITIES IN THE HSA

Three of the nine HSAs in the sample had not carried out plan implementation activities as of the time of the interviews. One HSA was just beginning its review activities and the remaining five had been reviewing for some time. None had performed appropriateness reviews because federal regulations for such reviews have not been written.

Review under P.L. 93-641 carries a potential for conflict because it involves a basic regulatory process. If negative recommendations are sent to the state agency or, in the case of certain federally funded programs, if a project is disapproved by the HSA, it is possible that the refused applicants will appeal and/or protest. Moreover, HSAs face a potentially hostile environment and controversial review process partly because they are not established, well-known agencies.

Most of the review functions of the HSAs are advisory in nature. For example, Certificate of Need, 1122, and appropriateness reviews involve recommendations by the HSA to the SHPDA, wherein final authority is vested. In undertaking these reviews, due to their advisory nature, the HSAs are:

- able to avoid some controversial situations; and
- unable to enforce their planning and regulatory goals unless the state agency's finding concurs with the HSA's recommendation. (Note that if the state agency's finding differs from the HSA recommendation and the HSA has a completed, accepted HSP/AIP, "the State agency must explain in detail" the basis for its decision. Moreover, an HSA has the right to appeal the state agency's decision.)

Nevertheless, under P.L. 93-641, HSAs do have some independent authority. Final authority, subject to appeal, is vested in the HSA with respect to reviews of the proposed use of funds provided by certain federal mental health and alcoholism programs. Only four of the nine HSAs discussed here have undertaken reviews of this kind. Two of these four, the Central Arkansas and Delta Hills HSAs, are fully designated and thus legally entitled to seek the enforcement of their approval/disapproval powers. The others, the Houston-Galveston and Permian Basin HSAs, have also been conducting these reviews but only on an advisory basis. As we will see, tensions may arise over the HSAs' performance of this function.

Arkansas

Central Arkansas HSA (CAHSA)

The CAHSA has been conducting review activities since its inception. In fact, the agency was acting as a project reviewer even before it received its initial conditional designation. To facilitate a smooth transition of the review function, the Executive Director (formerly Director of the 314(b) agency) obtained the 314(b) agency's consent to allow the HSA Steering Committee to act as the 314(b) advisory council for the three or four months preceeding CAHSA's initial designation. In this way, according to the Executive Director, the changeover was so smooth that

applicants did not notice the transition of authority over the review process. In his view, the fact that his agency included review activities among its earliest functions contributed to the smooth transition of a potentially controversial function and to its subsequent ability to function effectively.

Compared to the other HSAs examined, CAHSA has carried out substantial review activities. A description of these activities and the process surrounding them deserves some attention.

C/N and 1122 Reviews

The Facilities Review Committee conducts Certificate of Need (C/N) and 1122 reviews of new institutional health services. In the HSA's first year of operation (with conditional designation), the Committee reviewed fifteen items for C/N totaling $17.5 million. Thirteen received the HSA's recommended approval while two did not. Furthermore, six prospective requests for review "never developed past a preapplication conference, because agency and state standards of need indicated a clear lack of need for the proposed new resources," according to the *1st Annual Report of CAHSA, Inc.* (April 1977). These six requests were all for additional nursing home services.

Between April and the time of our interviews in November 1977, the HSA had not turned down any facilities applications. In one instance, the Facilities Committee recommended disapproval of a nursing home, but the Governing Board's votes were split evenly and no comment was made by the HSA.

In another case, two new computer tomography (CT) scanners were proposed. The Board encouraged the two applicant facilities to decide among themselves which could and which could not install the equipment. But, after an emotional five-hour meeting attended by a large contingent of radiologists, the Board chose to recommend both scanners.

Reviews of Proposed Uses of Federal Funds

During the HSA's first year of operation, forty-four projects involving the use of federal funds were reviewed by the Project Review Committee. In that first year, the HSA only commented on the proposals. However, now that the agency is fully designated, it is attempting to exercise the power of review and approval or disapproval. A "Manual for Review and Comment" was prepared in October 1977. However, since the regulations clarifying the division of roles and authority on reviews of proposed uses of federal funds were not yet written, much confusion, maneuvering for position, and conflict resulted.

It was clear during our visit with the CAHSA's staff that one of their primary goals was to have their authority to approve or disapprove these projects clarified. The Executive Director complained about the DHEW delay in the writing of the review and approval/disapproval regulations. He discussed the situation and what he was trying to do to change it. He speculated that the reason for the delay in the regulations was that officials of certain federal programs (e.g., mental health, alcoholism) oppose HSA review and approval powers and are fighting them in DHEW's Office of General Counsel.

In addition, the Executive Director was quite aware of the important role the Arkansas HSAs might play in paving the way for other HSAs throughout the country. "We're out in front" in acquiring and defining HSA authority, he stated.

Just before our visit to the HSA site, the Project Review Committee indicated its disapproval of a preliminary application for approval of a proposed mental health project in Little Rock. This project would have involved the annual expenditure of $800,000 for a period of five years. The Project Review staff person said that the project's proposal was inadequate. At the Project Review Committee meeting, the applicants, upon receiving the negative HSA assessment, replied that they would be able to undertake their project anyway, without HSA approval. Apparently, allusions were made to the use of favorable political and bureaucratic channels that might bypass and/or overturn the HSA ruling. One should note the potential extent to which channels of political influence may be mobilized when HSAs assume regulatory, cost control and, inevitably, allocative roles via their powers of review and approval or disapproval.

In sum, it is clear that the CAHSA has been quite busy with the reviewing function since its initial designation in April 1976. All of its reviews have been either C/N, 1122, or project reviews. Since federal regulations had not yet been written, no appropriateness reviews had been undertaken and there was no mention of any immediate intention to do so. Since September 1977, when it became one of the first HSAs in the country to receive full designation, the agency has been trying to clarify and establish its review and approval/disapproval authority. Not only is the Central Arkansas agency busy with the review function, but it also evidences little, if any, hesitancy about increasing its regulatory role.

Delta Hills Health Systems Agency (DHHSA)

The Delta Hills HSA, also in Arkansas, has been active and systematic in the performance of the review function. The DHHSA conducts its reviews through two committees: the Project Review Committee and the Review of the Use of Federal Funds Committee. The former conducts Section

1122 and Certificate of Need (C/N) reviews and, in the future, will conduct appropriateness reviews. The latter conducts reviews of proposed uses of federal funds.

C/N and 1122 Reviews

In the sixteen-month period between April 1976 and August 1977, the HSA and its Project Review Committee reviewed seventeen proposed projects, making recommendations on each to the state agency. All of these projects were reviewed under the Section 1122 and C/N systems of review. On July 28, 1977, the Project Review Committee's "Policies, Procedures and Criteria for Certificate of Need Review, Capital Expenditures Review, and New Institutional Health Services Review" was approved by the Governing Board.

Ten of the seventeen projects were reviewed favorably by the staff and committee. Five received unfavorable recommendations, one received no comment, and two proposals were withdrawn by the applicants before HSA recommendations were made. These reviews require some discussion.

Of the ten that received favorable recommendations from the HSA, all but one was approved by the state agency. The latter case remained uncertain at the time of the interviews, as the applicant had requested a hearing after learning of the state's disapproval decision.

Of the five proposals receiving unfavorable comments from the HSA, two were amended and eventually received approval. One of these involved a proposed expansion of ancillary services in a hospital. After the staff recommended disapproval of the mammography and cobalt therapy services which had been included in the original proposal, the applicants amended their proposal to the satisfaction of the staff and the HSA. In the other case of approval following amendment, the construction of a thirty-five-bed hospital and a thirty-five-bed nursing home had been proposed originally. After its initial disapproval by the staff (the review committee had not yet discussed the proposal) the proposal was amended to involve the construction of an outpatient clinic with an emergency room and sixty nursing home beds. As a result of this amending process, which was essentially an alteration of the applicants' original intent, the estimated cost of the project was reduced from $1.9 to $1.7 million. More significant, however, is that the HSA helped to stimulate the building of outpatient, not inpatient, facilities.

Two applications were withdrawn after a "presubmission conference." One applicant proposed a new 126-bed hospital, costing $1.2 million, while the other application involved the conversion of an existing clinic into an outpatient surgery center, costing an estimated $100,000.

Finally, one application received no comments from the HSA's staff and Project Review Committee. Nevertheless, it was approved by the Arkansas SHPDA.

Reviews of Proposed Uses of Federal Funds

A final review responsibility of HSAs that serves to restrict health services is the review and approval or disapproval of proposed uses of certain federal funds. The DHHSA's Review of the Use of Federal Funds Committee performs this function. This committee drafted a document detailing the policies, procedures, and criteria applicable to these reviews. After a public hearing held on July 28, 1977, this document was approved by the Board and subsequently published and distributed by the HSA. Prior to the adoption of this document, reviews of proposed uses of federal funds were carried out by the staff.

Appropriateness Reviews

Although the Agency has not yet established policies and procedures for conducting appropriateness reviews, it has written a plan with which it will develop these policies, procedures, and criteria. The "Appropriateness Review Plan" states as its goal the review for appropriateness of all existing health services offered in an institutional setting in the Delta Hills Health Service Area by October 1, 1980. Also, the Plan sets February 15, 1979 as the deadline for the adoption by the Board of a document detailing the HSA's policies, procedures, and criteria for appropriateness reviews.

Besides setting deadlines, the "Appropriateness Review Plan" discusses the basis on which such reviews will be undertaken. First, the HSA will examine the appropriateness of particular services in particular geographic service areas. Second, according to the Plan, if the service is deemed appropriate for a service area, yet several institutions in that area offer the particular service under review, then the HSA will review the appropriateness of the service within each of those institutions.

Finally, it should be noted that the DHHSA is aware of the fact that it must wait for federal guidelines on the appropriateness review process before it can proceed with the bulk of its planning for these reviews. Like the Central Arkansas HSA on reviews of the use of federal funds, the DHHSA perhaps is "out in front" on the appropriateness review function, and thus, might provide a stimulus for Congressional and DHEW action. Nevertheless, this stimulus will most likely not be sufficient to induce substantial movement at the national level on such a potentially controversial and highly regulatory function as reviews of existing institutional services.

General Comments: Delta Hills HSA

In sum, then, the Delta Hills HSA, like its neighbor in Central Arkansas, has been extremely active in performing several types of reviews–C/N, 1122, and Proposed Uses of Federal Funds. In addition, apparently more than any of the other HSAs in the sample, it has been planning for appropriateness reviews.

The Delta Hills experience yields two general observations. First, the procedures and structures surrounding the HSA's C/N and 1122 reviews of new institutional services appear to have operated to restrict, redirect, and/or deter the provision of new institutional services. For example, two initial applications to the DHHSA were withdrawn after a presubmission conference, and two proposed projects were amended. These withdrawn and amended proposals might illustrate the restrictive force of the HSA (e.g., elimination of some expensive services from a proposal) and even its potential constructive and developmental effect (e.g., encouraging the substitution of outpatient for inpatient facilities). The latter potentiality is illustrated by one review case, in which a proposed hospital was replaced by a proposed outpatient clinic; this redirection of health services might be attributed, in part, to the HSA threat to comment unfavorably on the proposed construction.

Second, since the DHHSA received full designation in September 1977, it can be anticipated that the activities of the Review of the Use of Federal Funds Committee will increase and, should the HSA choose to exercise final disapproval of many proposed projects and programs, possibly become involved in an increasingly controversial regulatory process. (As noted above, controversy has already arisen at the Central Arkansas HSA when it attempted to exercise its disapproval powers.)

Review activities in the HSAs in Texas and Oklahoma have not been as extensive as those at the Central Arkansas and Delta Hills HSAs. Nevertheless, their efforts are worth examining.

Texas

Houston-Galveston HSA (HGAHC)

The Houston-Galveston Area Health Commission, which serves as the area's HSA, has been undertaking a large number of reviews of proposed uses of federal funds, some C/N reviews, and no appropriateness reviews.

Reviews of Proposed Uses of Federal Funds

Reviews of the proposed use of federal funds are undertaken by the HGAHC's Project Review Committee. At the time of the interviews, it was the most active of the HGAHC's committees, averaging about ten reviews per month. The Committee consists of four consumers and four providers, but its expansion by five members is contemplated in order to meet the expected increased workload due to the initiating of the C/N and appropriateness review processes.

At the time of the interviews, the HSA was conditionally designated and thus was not attempting to exercise disapproval powers. Instead, it was commenting on proposed projects. Generally, the Project Review Committee's comment is approved by the Steering Committee, which acts on behalf of the Commission.

A discussion of two recent review cases may best portray the agency's experience. First, the review process is illustrated by the Committee's review of a proposed outreach program in Galveston County. In this case, after some delay, the Committee finally approved the project when its members were satisfied that the applicant would comply with their request for the inclusion of quantitative data in the project plan.

A second case portrays an ambiguity of authority between the HGAHC (the HSA) and its parent body, the Houston-Galveston Area Council (HGAC). A decision by the Texas Health Facilities Commission (THFC) was scheduled for January 1978 on a proposed forty-bed hospital in a small town in Harris County. The HGAHC (the HSA) had commented unfavorably on the hospital, claiming the area was already overbedded. The HGAC, in contrast, supported the project. At the time of the interviews, uncertainty existed over which agency's recommendation would be followed by THFC. Interviewees acknowledged that whatever the decision, a precedent would be set which would clarify the relative authority positions of the HGAC, a body of local elected officials, on the one hand, and the HGAHC, a health planning body consisting of professional planners, providers, and interested consumers, on the other. In sum, the ambiguities in the law and in the process, particularly regarding the division of responsibilities and powers between a public HSA and its overhead public planning commission, represent a major problem that the HSA was encountering at the time of our investigation.

C/N Reviews

The HGAHC began C/N reviews in September 1976 when it received its initial conditional designation. In the three months after designation, the agency held hearings on approximately one dozen applications for C/Ns. Several of the applications, especially those for computer tomography (CT) scanners, received negative comments from the HSA. However, all applications received Certificates of Need from the Texas Health Facilities Commission (THFC).

In December 1976, the agency suspended its C/N review

activities. The major reason for this suspension was that the THFC's rules for the C/N review process were inconsistent with federal regulations, and thus, the HSA was unable to develop adequate procedures for its receipt and review of applications. Nevertheless, beginning in January 1977, the HSA staff and Steering Committee, with Executive Committee authorization, have been conducting case-by-case reviews of proposed health services.

Appropriateness Reviews

Appropriateness reviews were not being undertaken by the agency at the time of the interviews. However, as noted in a previous section, the agency's plan development program included as an objective the development of procedures and criteria for such reviews.

Summation

In sum, the Houston-Galveston Area Health Commission, despite its conditional status, has been active in C/N and proposed uses of federal funds reviews, but inactive, due to the lack of federal regulations, on appropriateness reviews. Full implementation of several of its review functions awaits the results of the new plan development process. No controversy between applicants and the HSA was evident. However, indications of an emerging jurisdictional conflict between the HSA and its parent planning council were discernible.

Permian Basin HSA (PBHSA)

At the time of writing, the PBHSA has undertaken many A-95 reviews, some of which involved proposed uses of federal funds. However, formal reviews of proposed uses of federal funds have not occurred. Nor has the HSA conducted C/N or appropriateness reviews, though some preparation for the former has taken place.

A-95 Reviews

Because the PBHSA is a public body attached to the Permian Basin Regional Planning Commission (PBRPC), it conducts the review and comment function for health services required under OMB Circular A-95. These reviews necessitate cooperation between the HSA and the PBRPC. The process by which these reviews are undertaken begins with a summary report on each A-95 application by the HSA staff, and then the HSA's Project Review Committee analyzes, modifies, and comments on the applications. Next, the Governing Board (HSA) does the same. Finally, the HSA's comment is forwarded to the Planning Commission.*

Between March 15, 1976 and April 11, 1978, thirty-eight A-95 reviews were performed. The Planning Commission and HSA Governing Board have agreed in their assessments in all of these cases. Only two have received unfavorable comment.

Reviews of Proposed Uses of Federal Funds

Because the PBHSA has been conditionally designated, it has not been exercising its review and approval/disapproval function on proposed uses of federal funds. However, in anticipation of full designation, the agency plans to include additional criteria for this function in its forthcoming HSP.

C/N Reviews

Texas lacks a DHEW certified C/N program, and thus, the PBHSA has not conducted C/N reviews. Nonetheless, the agency has produced a document outlining its C/N review procedures and a "Content Review Form" for review of applications by the Project Review Committee. An additional form is provided for situations in which competing proposals, i.e., two or more applications that propose similar services, are to be considered.

Moreover, the Project Review Committee has adopted the C/N criteria developed by the Texas Health Facilities Commission. A provision has been included which enables the HSA to adopt additional criteria as long as they are consistent with the statutes and Commission rules and as long as the prior approval of the THFC is obtained.

Appropriateness Reviews

The agency staff indicated that procedures for appropriateness reviews would be incorporated into a revised Projects and Services Review Management system in May 1978.

Camino Real HSA (CRHSA)

At the time of the interviews, the Camino Real HSA was just beginning to conduct C/N reviews; it had not begun reviews of proposed uses of federal funds nor appropriate-

*In practice, the PBRPC sometimes reviews and comments before the HSA has taken up the matter. For example, in both cases in which a negative comment was registered by the PBHSA, the PBRPC had already conducted its review.

ness reviews. However, a few months later, C/N reviews were halted because of DHEW's deferral of the HSA's application for full designation.

C/N Reviews

In August 1977, the Board adopted a document entitled, "Procedures and Criteria for Certificate of Need Review," culminating a year of work by the staff and the Health Project Review Committee. According to this document, C/N reviews will involve review at two stages. At the first stage, each of the area's two SACs will review applications for new facilities within their areas. The second stage of the review will be conducted by the HSA's Board of Directors. Despite one SAC's request that its representatives on the Board be bound by SAC decisions, the first stage SAC recommendation will not be binding on any members of the Board at the second stage.

One procedural problem has arisen in the C/N review system. The federal and state requirements regarding the length of time allowed for review proceedings are not consistent with one another. The CRHSA chose to follow the State of Texas requirements for forty-five-day notice, and therefore, its procedures did not comply with DHEW regulations which require sixty days. Consequently, DHEW has stipulated that it will not approve the CRHSA's C/N review procedures until this timing problem is corrected to be consistent with federal regulations.

The agency waited until its HSP and AIP were completed before it began C/N reviews. Accordingly, in December 1977, when the agency's application for full designation (including the HSP and AIP) was submitted, it began the review activities. From then until February 1978, eight reviews were completed. The only application to receive a negative comment involved a facility for a proposed Health Maintenance Organization (HMO). However, in February, when action on Camino Real's application for full designation was deferred by DHEW, the agency halted its C/N review activities.

Reviews of Proposes Uses of Federal Funds

In August 1977, the agency began developing a document to be entitled "Procedures and Criteria for Review and Approval/Disapproval of Proposed Uses of Federal Funds." Nonetheless, it had not begun conducting these reviews by December 1977. Staff members indicated that the agency was awaiting fully designated status before undertaking such reviews.

General Comments: Camino Real HSA

At the time of the interviews, the CRHSA was on the verge of entering into the regulatory activities associated with the review process. It had delayed this process until a draft HSP had been prepared. C/N reviews did not begin until the HSP and AIP were completed and were halted a few months later. Furthermore, commencement of reviews of proposed uses of federal funds have been postponed until full designation status is acquired.

Interviewees active in this HSA indicated reservations concerning the review process. Some expressed the opinion that review is an inappropriate function for a planning agency. Instead, some believe that the state, not the HSAs, should conduct reviews and exercise regulatory sanctions, in particular those relating to appropriateness review and cost containment, while at the same time maintaining the consistency of these review decisions with local plans developed by the HSAs.

Northeast Texas HSA (NTHSA)

The NTHSA has chosen to postpone its implementation of C/N reviews of new institutional services until (1) the agency's HSP and AIP are completed (expected in August 1978), (2) the Texas C/N program is certified by DHEW, and (3) the Texas Health Facilities Commission publishes criteria for C/N reviews. Also, the agency does not plan to undertake reviews of proposed uses of federal funds until it is fully designated, nor appropriateness reviews until federal regulations pertaining to such reviews are promulgated.

It is expected that once in operation the C/N review function will be performed by the Executive Committee or a new review committee. Controversial cases probably will be submitted to the full eighty-nine member Governing Board for consideration.

Interviewees anticipated that review activities will be unpopular among the members of the HSA as well as among the public. The reasons for this are twofold. First, many feel that the national guidelines (CFR 42, No. 185, September 23, 1977) did not address rural needs adequately, and therefore are inappropriate as review criteria for the Northeast Texas Health Service Area. Second, many were apprehensive of political entanglements. A fear was expressed that political considerations, rather than rational planning, may remain the most important factors in deciding sensitive issues in health care services.

South Texas HSA (STHSA)

At the time of the interviews, the STHSA's operations did not include review activities. The agency was neither conducting nor preparing to conduct C/N, proposed uses of federal funds, or appropriateness reviews. Instead, the agency was concentrating its efforts solely on the development of an HSP and an AIP.

As noted above, there are several possible reasons for this HSA's slow development. First, the fact that initially each SAC was allowed to develop its own area plan has probably resulted in a cumbersome planning process, which almost inevitably results in delayed development of a review system. (Note, however, that this plan development process may both increase community members' access to the HSA and decrease the amount and intensity of criticism arising *after* completion of the plans.)

Second, more than the other HSAs in our sample, the STHSA exists in a political environment characterized by ethnic and geographic divisions. These may have contributed to the HSA's delayed entrance into the potentially controversial regulatory process of review. The HSA faced a lawsuit which charged that the Governing Board was not "broadly representative" of all groups in the area. Furthermore, prior to its original conditional designation, the STHSA encountered competition from the South Texas Health Consumers Association, which claimed that it better represented the poor and Mexican-Americans, and which subsequently initiated a lawsuit. These factors increase the difficulties associated with the process of reconciling differing groups, interests, and Subarea Councils.

Finally, the delayed development of the Texas SHCC, the noncompliance of the Texas C/N program with federal regulations, and the failure of DHEW to write regulations for the review and approval/disapproval of proposed uses of federal funds have all combined to produce an atmosphere of delay and uncertainty sufficient to encourage hesitancy among some local agencies.

Central Texas HSA (CTHSA)

Like the STHSA, CTHSA had not undertaken review activities at the time of our investigation. Nevertheless, these functions were clearly on the minds of many staff persons. Some of the plans and concerns expressed are discussed below.

Although Certificate of Need reviews were not being conducted by the agency, it had been working on the development of procedures for such reviews. Work on these procedures, however, was discontinued in late November, when DHEW's Project Officer advised the agency to wait until the Texas Health Facilities Commission's final rules are written.

Appropriateness reviews were scheduled to begin sometime in 1978. Two alternative ways of conducting such reviews were proposed. For one, a survey would be used to assess needs and discern referral patterns. Subsequently, this survey would be used to determine which, if any, facilities should be closed. The second alternative mechanism for such reviews is an undertaking of a feasibility study, preferably using federal funds. Or, if federal money is not forthcoming, the federal guidelines would be substituted for the agency's assessment of the area's needs. In any case, this second system, like the first, might provide information and criteria to facilitate decisionmaking on the appropriateness of existing institutional health services.

In conclusion, then, although not yet performing the review function, CTHSA staff members are cognizant of, and to some extent planning for, the inevitability of exercising review powers in the future. However, agency personnel remain hesitant to undertake this regulatory responsibility. The general aprehensive sentiment expressed was that the agency lacks sufficient powers and resources with which to achieve adequate progress in both health planning and cost control.

Oklahoma HSA

At the time of the interviews, the OHSA was active in C/N and 1122 reviews but inactive in project and appropriateness reviews. The Oklahoma Health Planning Commission (OHPC) has been conducting 1122 reviews since 1974 and C/N reviews since 1976, when the State's C/N legislation went into effect. Since undertaking the review and comment function, the OHSA has discovered its relative lack of power vis-à-vis the OHPC. The general, summative discussion that follows will clarify this and other points.

The OHSA's experience with the review process illustrates several general problems that are likely to emerge in other HSAs as well. First, tension between the HSA and its SACs over the division of reviewing responsibilities and authority has begun to emerge. It appears that the SACs, in general, seek a larger role in future reviews than the HSA staff considers to be desirable.

Second, conflict has already emerged between the HSA and the Oklahoma Health Planning Commission. Cases have occurred in which the OHPC has overturned an HSA recommended disapproval of a proposed facility. In one specific instance, after the HSA unanimously recommended disapproval of a nursing home proposal, the OHPC approved it. The HSA has responded to situations such as these in two ways which its members hope will place future HSA decisions on firmer ground in relation to the OHPC. For one, it has requested that state lawmakers amend the C/N law so that it complies with federal regulations. Specifically, the HSA has urged the inclusion of a provision granting the HSA the right to appeal C/N decisions made by the state agency. With this legal mechanism, the HSA staff felt that their threat to appeal might deter, to some extent, the OHPC from disregarding entirely the HSA's recommendations on proposals seeking Certificates of Need.

The second and major way in which the HSA hoped to enhance its powers was to gain fully designated status. With

such status, staff members feel that (1) the state agency might take the OHSA's comments on C/N requests more seriously and (2) the HSA should be able to exercise legally the disapproval sanction over proposed uses of federal funds.*

Third and finally, a case involving the proposed City of Faith Hospital illustrates the large extent to which the Certificate of Need review activities of an HSA can receive public attention. In this case, a new Tulsa hospital has been proposed by the well-known evangelist, Oral Roberts. The HSA, reporting that it would cost $150 million and there is an estimated surplus of 1,000 beds in five Tulsa hospitals, voted nineteen to six in February 1978 to recommend disapproval to the state agency, the OHPC.

Meanwhile, immediately following the HSA's negative comment, the case received national media coverage on NBC News on February 27, 1978. Clearly, this HSA's attempt to exercise the restrictive element of its review functions aroused public attention to and awareness of both the proposed City of Faith facility and the functions and sanctions of HSAs. In sum, this particular case exemplifies the precariousness of HSA activities. Despite its unfavorable comment, two more decision points, the state agency and the court system, remained in C/N reviews. Both were potentially surrounded by highly visible politics and extensive media coverage; at either point the HSA's recommendation could be overturned. Subsequently, as discussed in Chapter III, the OHPC did grant the City of Faith Hospital a Certificate of Need.

ENCOURAGING HEALTH SYSTEMS DEVELOPMENT

The Statutory Responsibility

Essentially, HSAs are empowered by P.L. 93-641 to perform two roles which may have the effect of encouraging the expansion of health services provided in its health service area.

(1) Under Section 1513(h), "each health systems agency shall annually recommend to the State health planning and development agency... (a) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (b) priorities among such projects."

(a) Under Section 1640, each health system agency which has a designation agreement, an HSP and AIP reviewed by the State Health Coordinating Council and is performing its functions in a manner satisfactory to the Secretary of DHEW, may receive a federal grant to establish an Area Health Services Development Fund from which it may make grants and enter into contracts the purpose of which is pursuit of goals established in the HSP and/or AIP of the agency. (This fund is commonly referred to as developmental fund.)

Activities in the HSAs

Although several HSAs have been actively encouraging health systems development, none of the nine HSAs in the sample have been able to distribute money as aids and incentives to such development. This is due to the fact that Congress has not made an appropriation for the Area Health Service Development Fund which, according to P.L. 93-641, is to be dispersed by HSAs in pursuit of goals established in the HSP or AIP.

A few of the HSAs in our sample have taken a first step toward planning for the performance of this plan implementation function. For example, the Houston-Galveston Area Health Commission had plans to include within its HSP and AIP documents (forthcoming in September 1978) recommendations to the Texas SHPDA of projects for the modernization, construction, and conversion of medical facilities in its area. Furthermore, this agency intends to include plans for the use of AHSDF monies in those planning documents. Similarly, staff members of the Permian Basin HSA expressed their intention to include suggested projects for the AHSDF monies in their AIP, the completed version of which was expected in March 1978.

In addition, the Central Arkansas HSA has attempted to stimulate the development of needed health services. For example, for a long period of time its staff members have been trying to organize a Board and proposal for a 24-hour clinic in the East End area of Little Rock.

Finally, at one HSA several of our interviewees expressed the view that the only way HSAs can be effective is to combine a "carrot" (e.g., grants for health service development) with their regulatory "stick" (i.e., restrictive reviewing functions). This view suggests that the negative implications of the regulatory function might be balanced by the positive function of distributing money to projects which adhere to the HSP. With AHSDF monies, the HSAs would be able to provide financial incentives to project applicants and others for developing health services which the AIP and/or HSP have deemed necessary. Without the money, the incentives for applicants to cooperate with HSAs are negligible.

In sum, some action has been taken toward the encouragement of planned health services development by some of the HSAs in our sample. In particular, those HSAs

*In reviews of proposed uses of federal funds, the state agency has no authority, and thus, HSA decisions will be final, subject to appeal to the Secretary of DHEW.

which have expressed some apprehension concerning their future review functions are seeking a positive developmental function to offset their more controversial review role.

PLAN IMPLEMENTATION: SUMMARY

The discussion above clearly indicates that the performance of the plan implementation function by the HSAs in our sample has varied. Some are conducting neither review nor encouragement activities, while others are actively considering C/N, 1122, and proposed uses of federal funds reviews and undertaking some encouragement activities. None of the nine HSAs had begun appropriateness reviews.

Comparisons at the state level yield some interesting differences. First, of the three states, Arkansas has made the most progress in its performance of the plan implementation function. The two Arkansas HSAs in the sample have actively performed reviews, have attempted to exercise their disapproval powers, and are not reluctant to adopt a regulatory, restrictive stance. In fact, one of the Central Arkansas HSA's chief concerns during the interviews was the nonexistence of federal regulations regarding HSA review and approval/disapproval of proposed uses of federal funds. Cognizant of the fact that their agency was one of the first in the country to attempt to exercise these powers, members of the CAHSA considered themselves leaders in the area of HSA review functions. Thus, in Arkansas, HSA reviewing was not uncommon and several of the state's HSAs were seeking to buttress their review powers with the yet-to-be-delivered federal regulations and AHSDF monies.

Second, in Oklahoma, the statewide HSA has been somewhat active in reviewing new institutional services, but it has confronted major problems. One is the existence of jurisdictional conflicts with the SHPDA, the Oklahoma Health Planning Commission. While the Commission has not hestiated to overturn the HSA's recommendations, the OHSA has lacked both a right of appeal and fully designated status, factors which if possessed, might strengthen its position vis-à-vis the OHPC.

Third and finally, only three of the six Texas HSAs in the sample have been active in the plan implementation function. The other half of the Texas sample has been almost totally inactive. Two Texas HSAs have been conducting the review and comment function for C/N and proposed uses of federal funds reviews. A third HSA was just beginning to put its reviewing apparatus into operation at the time of the interviews. Nevertheless, because all had lacked fully designated status, none of these three HSAs were attempting to exercise disapproval powers over the federally funded categorical programs.

In summary, the nine HSAs in the sample might be clustered into three categories regarding their performance of the plan implementation function. In one category are the two Arkansas HSAs. Being fully designated, they are attempting to exercise all of their statutory authority. In a middle category one might place the Oklahoma, Permian Basin, Houston-Galveston, and Camino Real HSAs. These agencies, only conditionally designated, are active in some review functions but are not able to exercise fully their statutory powers until fully designated status is achieved. And indeed, some of these moderately active agencies, either in fear of or in ideological opposition to regulation, seem to have no intention of exercising negative sanctions. Finally, in the last group are the Northeast, Central, and South Texas HSAs. These HSAs are either not yet at a stage of development which would facilitate active review or, like some of the moderately active agencies, are hesitant to enter the regulatory arena.

Finally, even the most active HSAs in our sample were not conducting nor prepared to conduct appropriateness reviews. Similarly, none were undertaking more than limited activities in the realm of encouraging health service development. Lack of action on these fronts, however, should not be attributed to deficiencies or lack of initiative on the part of the HSAs. Rather, the lack of federal guidelines and the nonexistence of a Congressional appropriation for the Area Health Service Development Fund are most likely the reasons for HSA inactivity in the use of their strongest negative sanction, appropriateness reviews, and their strongest positive inducement, area health service development grants.

TABLE 4
PLAN IMPLEMENTATION AT NINE HEALTH SYSTEMS AGENCIES

	ARKANSAS		TEXAS						OKLA-HOMA
Plan Implementation Activity	*Central Arkansas*	*Delta Hills*	*Houston-Galveston*	*Permian Basin*	*Camino Real*	*Northeast Texas*	*South Texas*	*Central Texas*	*Oklahoma*
I. Restricting:									
a) C/N Reviews	Active	Active	Active (9/12/76) Suspended activities in Dec. 1976	Preparing	Active (Dec. 1972) Suspended activities in Feb. 1978	Inactive	Inactive	Inactive	Active
b) 1122 Reviews	Active	Active	NO 1122 AGREEMENT						Active
c) PUFF Reviews	Active	Starting	Active (commenting only)	Active (commenting only A-95 reviews)	Inactive	Inactive	Inactive	Inactive	Inactive
d) Appropriateness Reviews	NO FEDERAL GUIDELINES								
II. Encouraging:									
a) Assisting in development of grant applications	Active	Active	Inactive	Inactive	Inactive	Inactive	Inactive	Inactive	Inactive
b) Recommendations to SHPDA for changes in medical facilities	Active	Inactive	Expected in forth-coming AIP	Expected in forthcoming AIP	Inactive	Inactive	Inactive	Inactive	Inactive
c) Grants from AHSDF	FUNDS NOT APPROPRIATED BY CONGRESS								

CHAPTER VI

INTERRELATIONSHIPS IN THE HEALTH PLANNING SYSTEM

It soon became evident from our interviews and our analysis of P.L. 93-641 that the institutions created by it (HSAs, SHPDAs, and SHCCs) are not the only important actors in the health planning policy arena. Rather, there are a large number of public and private health-related organizations at the local, state, and federal levels which must be involved in health planning under P.L. 93-641 if the Act is to accomplish its purpose of planning for and reorganizing the U.S. health care system. These other actions include the general public, consumer and labor groups, provider and health-related interest groups, local governments, state health-related agencies, governors, and federal health agencies. All have an interest in the health planning conducted under P.L. 93-641, and all must be involved if a truly comprehensive health planning program is to be developed.

The question then becomes how these other actors are to be involved in health planning. Traditional organizational theory states that there are likely to be two answers to this question. First, a formal organization and process can be instituted to insure that each of the interested parties is provided an opportunity to be heard and to present its views on health planning. Second, an informal organization can be developed to allow each of the parties the opportunity to work on a less formal basis with the institutional actors (HSAs, SHPDAs, and SHCCs) to articulate their views on health planning. At least in part, P.L. 93-641 provides that the views of interested parties are to be articulated through a formal organization and process established by the Act. For example, most of the major actors (providers and consumers) are accorded formal representation in the institutions created by the Act (HSA Governing Boards and SHCCs). In addition, all meetings and processes must be open to the public and interested parties, and all health plans developed under the Act are to be the subject of public hearings.

Our research indicates that the second method of involving other actors is also used. In each state an informal organization has been developed to allow many viewpoints to be articulated in the process of health planning. The informal organization often takes the form of study groups, data sharing, and *ad hoc* arrangements. The nature of the informal organization and the extent to which it is used varies in each state.

A related question is how the input obtained from the other actors is used by the health planning agencies created under the Act. That is, does the planning agency see itself as an independent collator of the information provided by the interested parties, or does it see itself as the advocate of all or certain of the views presented?

The aim of this chapter is to analyze the interrelationships among institutions created by P.L. 93-641 and other health-related actors in each of the states reviewed. The analysis focuses on (a) the nature of the relationships, formal or informal; and (b) the purpose or use of the relationships. It examines the relationships among HSAs and other local, state, and federally-oriented actors, and the relationships developed by the SHPDAs with other local, state, and federally-oriented actors. It also analyzes the interrelationships between HSAs and SHPDAs in Arkansas, Oklahoma, and Texas.

ARKANSAS

This section of Chapter VI examines the interrelationships which have developed in the health planning structure in the State of Arkansas. It reviews (a) HSA relationships with other groups, (b) SHPDA relationships with other groups, and (c) relationships between the HSAs and the SHPDAs.

HSA Interrelationships

As in other states, the Arkansas HSAs have concentrated on developing relationships with the two major health related interest groups which they are required to involve under the terms of P.L. 93-641; i.e., providers and consumers of health care. This is in addition to establishing the necessary relationships with the SHPDA which will be discussed below. The HSAs reviewed in this study have primarily involved providers and consumers through representation on the HSA Governing Board. Individual providers and consumers are members of the governing board, and nominations for board openings are solicited from provider and consumer groups and associations. Local government officials have also been involved in HSA operations in this way.

The Arkansas HSAs reviewed in our study do not use SACs, Task Forces, or other advisory councils to involve providers and consumers other than those on governing boards, as extensively as in the other two states. The Central Arkansas HSA (CAHSA) uses only one task force which draws part of its members from outside the Governing Board, while the Delta Hills HSA (DHHSA) has no such group. Neither HSA has SACs. These HSAs feel that their nominating and board selection procedures, along with public meetings, hearings, etc., serve to secure widespread public input into their operations.

The CAHSA, however, has instituted one extraordinary measure to obtain public involvement in its operations. It has formed an HSA Corporate Body, the responsibilities of which are to elect the members of the HSA Governing Board, to serve on committees, and to nominate persons for board positions. Membership in the Corporate Body is open to any citizen of the CAHSA service area who attends an Annual Meeting or completes a corporate membership form. The Corporate Body is intended to be a method of gaining consumer involvement and participation in the HSA. However, of the approximately 700 current official members of the Body, over 375 are employees of St. Vincent Hospital in Little Rock. The Administrator of St. Vincent's is a member of the Governing Board and encourages the employees to become Corporate Body members. The effect of this employee affiliation on the actions of the body or the individuals is not known, but the case demonstrates that efforts to involve consumers in HSAs may not always achieve their intended purpose.

The CAHSA has experienced one aspect of consumer involvement which is uncommon in other HSAs in our sample, i.e., consumer organization involvement. The Arkansas Community Organization for Reform Now (ACORN) was extensively involved in the early operations of the HSA. It monitored HSA activities, presented testimony at public hearings and worked to have a 24-hour clinic for the East End of Little Rock included in the HSP. However, after having three of its members elected to the HSA Governing Board, its involvement as a group in the HSA has waned somewhat. Organized consumer participation is the exception, rather than the rule, in HSAs.

In the Delta Hills HSA, most respondents believe that hospital providers are quite active. Several interviewees stated that most conflict on this board was likely to be among providers rather than between consumers and providers. Consumer education and participation on this board was somewhat low, primarily because of the limited funds available and the lack of active consumer groups in the area. The staff of this HSA was eager to have consumer participation. The professionalism of the staff and their active involvement in the health planning process has been remarkable for a minimally funded HSA.

In addition, the Arkansas HSAs have formed a cooperative working relationship with the Dallas Regional Office of DHEW. The HSAs use the Regional Office as a source of information on the requirements of the Act and to obtain interpretations of regulations, etc. The relationship with the Regional Office is used to insure that things work smoothly and appropriately. Unlike the Texas experience, no serious conflicts have developed between the Arkansas HSAs and the Regional Office. The HSAs have, however, found that the Regional Office is not a good vehicle through which to force action on the part of the federal government. To obtain a clarification of the proposed use of federal funds review authority, the HSAs have attempted to use U.S. Senators, in particular Senator Dale Bumpers, to force action from Washington DHEW, rather than communicating their concerns through the HEW Regional Office.

In brief, it appears that the Arkansas HSAs reviewed in this study have primarily channelled the involvement of the other parties interested in areawide health planning through the formal organization established in P.L. 93-641. Both HSAs solicit nominations for governing board membership from a wide variety of groups and individuals, including providers, consumers, and local government officials. However, beyond this and the use of technical advisory committees by Delta Hills, the HSAs have made few efforts other than public meetings, public hearings, and the Corporate Body of CAHSA to obtain widespread involvement.

SHPDA Interrelationships

As in the other states, the Arkansas SHPDA has also developed a rather extensive set of interrelationships with other state health related agencies, particularly the State Department of Health. The purpose of the relationships is to involve these agencies in the statewide health planning undertaken by the SHPDA and to insure that state government interests are reflected in the planning and regulatory processes of P.L. 93-641. Primary among these is that the Directors of the State Department of Health and the State Department of Human Resources are members of the SHCC. This is not required by law as in Oklahoma, but was done at the initiative of Governor Pryor in making his appointments to the SHCC. This cross-membership insures that the interests of these agencies, the programs of which will be reviewed by the SHCC and addressed in a State Health Plan, will be represented in the deliberations of the SHCC.

The SHPDA has also established several further formal and informal relationships with the State Department of Health. First, the SHPDA has contracted with the Bureau of Health Facilities of the Department to conduct the statewide medical facilities inventory and to monitor

compliance with the indigent service requirement of the Hill-Burton program. Second, the SHPDA Director communicates directly with all segments of the Department by attending the weekly staff meeting of the Health Department Bureau Chiefs. Finally, in October 1977, there was a series of meetings between Bureau Chiefs of the Health Department and the directors and staffs of the four HSAs in the state to open an avenue of communication among the participants in P.L. 93-641.

In addition, the Arkansas SHPDA has worked with other state health agencies in developing the statewide needs, policies, and programs components of the State Health Plan and to obtain data for HSAs to use in the development of their HSPs and AIPs. It has established working relationships with the University of Arkansas Medical Sciences Campus and its Schools of Medicine, Nursing, Pharmacy, and Allied Health Professions, the University Division of Biometry, the Arkansas Industrial Research and Extension Center (population and socioeconomic data), and the State Cooperative Health Statistics Center.

The final relationship with state government which is important to the SHPDA is with the Office of the Governor. The SHPDA Director is appointed by and serves at the pleasure of the Governor. The Governor's Office was instrumental in drafting legislation to implement P.L. 93-641 and the Governor worked to smooth the transition to the new structure. Governor Pryor allowed the combined HSA representation on the SHCC to exceed the required 60 percent in an effort to make the selection process work smoothly. In addition, it is expected that the interest of Governor Pryor in health care issues and his direct lines of authority to the SHPDA and other health agencies will make the task of coordination and communication among the agencies easier and help insure that state interests are reflected in the P.L. 93-641 planning and regulatory processes.

The Arkansas SHPDA has also developed relationships with private, nongovernmental interest groups. In particular, the Arkansas Hospital Association (AHA) has worked closely with the SHPDA. On the recommendation of the AHA, the State Certificate of Need law (Act 558 of the 1975 Legislature) contained minimal procedural detail, but rather basically instructed the SHPDA, with the approval of the SHCC, to develop a C/N program to meet the requirements of the federal law and regulations. This aided Arkansas in developing the first certified C/N program in the nation. AHA also worked with the SHPDA to develop a single set of C/N and 1122 review procedures and criteria. The Arkansas SHPDA appears to be relying on the HSAs to involve health care consumers and the general public in the P.L. 93-641 planning and regulatory processes.

In brief, the Arkansas SHPDA has concentrated its efforts on involving other state health related agencies and statewide organizations. It appears to enjoy a closer relationship with the Governor than those in the other states. Along with the Governor's lines of authority to the SHPDA and other agencies, this should ease coordination and communication among them.

HSA/SHPDA Interrelationships

That the Arkansas HSAs and SHPDA have developed an effective cooperative working relationship is obvious. The four HSAs and the SHPDA simultaneously submitted application for full designation to HEW and had them approved. This made Arkansas the first state in the nation to achieve full designation of all its HSAs. Also in this process, the HSPs of the four HSAs were approved. In addition, an approved Certificate of Need program has been implemented in the state. There has been little conflict between the HSAs and the SHPDA, despite the fact that the SHPDA has, on at least ten occasions, overridden the recommendations of HSAs. Further, the Arkansas HSAs are working to clarify the authority relationships for the review and approval of proposed uses of federal funds. In short, the Arkansas HSAs and SHPDA have clearly worked together to implement P.L. 93-641 in the manner intended in the Act and have progressed, organizationally at least, to a point beyond that achieved in most, if not all, other states.

What is not immediately obvious are the factors or structural arrangements which would allow Arkansas to achieve this advanced implementation status. It does not appear that the agencies–HSAs and the SHPDA–have developed any extraordinary organizational or structural arrangements beyond those developed in Oklahoma and Texas which would assist them in implementing the Act without the conflicts which have occurred in other states. The structural arrangements which have been used in Oklahoma and Texas and which are used in Arkansas include:

- the HSAs and the SHPDA developed a common format for the HSPs and the SHP. This format was never approved by the SHCC. It was used by only three of the four HSAs; Delta Hills HSA used a "systems approach" for developing its HSP, and its organization differed substantially from that of the others;
- the HSAs and the SHPDA have formed a joint staff Medical Facility Committee for data sharing and technical assistance in medical facilities planning;
- the SHPDA has assigned HSA liaison activities to a staff person;
- two state government officials serve on the SHCC; and
- HSA and SHPDA officials hold regular meetings with one another.

These measures are not, however, substantially different from those implemented in Oklahoma and Texas. They do not seem to explain how P.L. 93-641 could be implemented in Arkansas without the conflict which occurred in the other states.

Some of the factors which help explain the high level of cooperation in Arkansas appear to be as follows. First, there is a recognition that the small staffs and limited funding of the HSAs and the SHPDA require that the agencies be mutually reliant on the expertise and processes of the other agencies. Staffing and funding levels do not allow duplicative planning and regulatory efforts. Second, the key officials in both the HSAs and the SHPDA were formerly associated with health planning in Arkansas under the 314 Comprehensive Health Planning Program. They currently serve in substantially similar positions and are accustomed to working with one another. Third, Arkansas Governor Pryor has taken an active interest in the implementation of P.L. 93-641 and has encouraged all parties to work together. Finally, there appears to be a feeling among the participants in Arkansas that if they work together and accomodate one another, all interests can be adequately represented and all parties can accomplish their goals. The feeling is that to openly engage in conflict with one another is to invite outside intervention from the federal government. The desire in Arkansas is to resolve all conflicts internally and quietly so that, as a group, the Arkansas agencies can accomplish the things they desire without federal interference.

Despite the advanced organizational status achieved in Arkansas, the Arkansas SHPDA Director expressed concern about the functional achievements of the agencies and about the ability of the organization established to actually alter the current health care delivery system. In particular, there is concern about the general effectiveness of the Certificate of Need process in controlling health care costs and fostering preventive health care.

In summary, the Arkansas HSAs and SHPDA have developed an effective working relationship which has enabled the state to progress beyond a point reached in other states in implementing P.L. 93-641. It appears, however, that it is informal and intangible factors which are responsible for this "success" rather than formal structural arrangements, and that in particular the active participation of the Governor helped integrate the different levels and helped expedite the process. Structurally, little has been done differently by the Arkansas HSAs and SHPDA than that done in Oklahoma and Texas, but conflict has not arisen in Arkansas as it has in the other states.

OKLAHOMA

The purpose of this section is to examine and analyze the interrelationships developed within the health planning structure in the State of Oklahoma. We examine (a) the relationships developed by the Oklahoma Health Systems Agency (OHSA) and various local, state, and federally oriented parties at interest; (b) the relationships developed by the Oklahoma Health Planning Commission (OHPC) with the same parties at interest; and (c) the interrelationship between OHSA and OHPC. Emphasis throughout is on the nature of the relationship, purpose of the relationship, and the use of the products of the relationship.

Oklahoma Health Systems Agency

The primary characteristic of the interrelationships developed by OHSA with other parties is the extent to which the formal organization appears to be the predominant vehicle for involving other interested parties. After initially extending the basic formal organization specified in P.L. 93-641 by creating six Subarea Councils, OHSA has developed a planning and regulatory system which relies almost exclusively on the formal organization of both the HSA and SACs for involving others in its health planning processes. OHSA has not demonstrated any aversion to involving other parties in its planning process; SACs were, in fact, created to increase involvement in health planning and to insure a forum at less than a statewide level for involving others. But once the SACs were created, the HSA attempted to insure that virtually all input into health planning came through this formal organization from the SACs up to the HSA Governing Board or through other formal processes such as public hearings.

Ways in which this is demonstrated include:

- SACs were the basic vehicle through which the initial HSP and AIP were developed. The HSP/AIP were developed from recommendations presented to OHSA by the SACs. Involvement in the planning process at both the SAC and OHSA level was accomplished primarily through public hearings.
- Appointments to the OHSA Governing Board come largely from nominees of the SACs. Eight persons are nominated for each open position; six of the nominees come, one each, from the SACs.
- Membership on all standing committees of OHSA is limited to members of the Governing Board or the SACs.
- All input into regulatory decisions of OHSA is funnelled through staff analysis and a public hearings process.

This is not to say that OHSA has developed a closed planning process in which it not receptive to ideas from others. OHSA definitely attempts to gain the involvement of others. It is to say, however, that OHSA has attempted to insure that this involvement occurs through a formal

process where all interests are accorded an equal opportunity to be heard. In achieving this, OHSA relies extensively on SACs as the vehicle for involving others.

Not all OHSA interrelationships occur through the formal organization. It has developed some informal relationships also. In particular, nominations for membership on Subarea Councils are obtained through an open, informal process. SAC appointments are made by the HSA Governing Board, but nominations are widely solicited from the general public, local governments, and health-related interest groups. Two of the eight nominations for each opening on the HSA Governing Board are also obtained from groups other than the subarea councils. In addition, OHSA maintains a Standing Task Force comprised of Governing Board members, SAC members and members of the general public, and interest groups to investigate problems on an *ad hoc* basis. It has also developed informal working relationships with local governments and provider groups for the sharing of data and ideas. Nonetheless, the predominant form of involvement appears to be through the formal organization and through formal processes.

This reliance on the formal organization is in keeping with the general view OHSA holds of itself in the implementation of P.L. 93-641. It sees itself as a central comprehensive health planning agency whose role is to provide independent analyses of the health care system in Oklahoma and to exercise independent judgement in the decisions entrusted to it under the Act. In this role it realized that it must rely on the advice and counsel of many other parties, but it sees itself as the party responsible for the analyses and decisions necessary to accomplish the purposes of P.L. 93-641. It does not see itself as an advocate for any particular point of view. To maintain its independence, OHSA apparently feels it must rely on rather formal processes in which all parties proceed on an equal basis and all have an equal opportunity to be involved in the activities it undertakes. To do otherwise would open OHSA to charges of favoritism or of being co-opted.

This view of itself has led to some conflict between OHSA and OHPC. Because of its belief in its independence and ability, OHSA has reacted with virtual righteous indignation on the limited number of occasions when OHPC has overturned OHSA decisions. The conflict arises, in part, because OHPC also sees itself as an independent planning agency responsible for regulatory decisions. The conflict is expected by both parties and has been accomodated thus far.

The predominance of the formal organization also serves another purpose for OHSA, in that it serves to limit the points of contact among the parties at interest in health planning to those under its control. This leaves OHSA as the primary arbiter of disputes and allows it to develop a consistent health plan it feels meets the needs of the state rather than reflecting the viewpoint of any interest group. While OHSA realizes there is an inherent conflict between certain of the parties at interest, such as providers and consumers, and state and local governments, it feels these interests can be adequately represented in the formal organizations and processes established in the Act. It feels further points of confrontation would be counterproductive. This is basically the viewpoint adopted at all levels in Oklahoma. It was first articulated by Governor Boren in his recommendation to establish only one HSA in the state.

An interesting situation is developing regarding the nature of OHSA interrelationships with other interested parties in health planning. As stated, OHSA relies extensively on the SACs as the vehicles through which to involve other parties. However, OHSA is currently taking steps to diminish the role of the SACs. It feels that since the basic planning documents are completed, the role of the SACs can now be reduced. The question then becomes what OHSA will do to insure that other relevant parties are involved in its activities? Will it rely only on its Governing Board, public hearings, public meetings, etc., to obtain input? Or, will it develop other mechanisms, such as less formal working relationships? The question is important because if the other parties at interest feel they are not adequately involved, OHSA may lose some of the cooperation it appears to have received from other groups. It is not possible to project what OHSA will do, but the situation merits observation.

Oklahoma Health Planning Commission Interrelationships

The Oklahoma Health Planning Commission also relies extensively on the formal organization specified in P.L. 93-641 to involve other relevant interests in its health planning activities. It has concentrated primarily on involving other state health-related agencies in the formal organization. To accomplish this, however, the basic formal organization has been modified somewhat by according both the Governor and OHPC some powers in addition to those envisioned in P.L. 93-641.

The most prominent step taken to involve others in the formal state organization is in the composition of the SHCC. In addition to the required membership from the OHSA Governing Board, the SHCC consists of representatives from most of the state agencies with health-related functions, including the Board of Health, Board of Mental Health, Public Welfare Commission, Regents for Higher Education, Emergency Medical Services, Physician Training Council, and the State Legislature. Through this membership, most state agencies with health-related functions are formally represented in the P.L. 93-641 planning process. This is particularly important to those agencies administering federally funded grant programs, the plans for which

are subject to the review and approval of the SHCC.

Other steps have also been taken to modify the basic P.L. 93-641 organization to ensure that state government interests are represented in the formal organization. First, a special role has been developed for the OHPC in the planning process. In addition to being *approved* by the SHCC, the State Health Plan and the State Medical Facilities Plan must be *adopted* by the OHPC before they become components of official state health policy. Second, the Governor has been accorded powers in the state health planning process in addition to those envisioned in P.L. 93-641. The Governor is responsible for promulgating and amending the SHCC bylaws and must be offered the opportunity to review and comment on the State Health Plan as approved by the SHCC. Further, under the current SHCC bylaws, it is cause for removal for a SHCC member to "arbitrarily or capriciously" ignore the comments of the Governor on the SHP.

OHPC has also worked informally to involve other state government agencies in its planning processes. It has arranged meetings between the state agencies and the SHCC and HSA to allow the agencies to explain their programs and the limitations under which they must work. OHPC also involves other state health-related agencies in its processes for developing the state policy sections of the State Health Plan.

OHPC has not developed relationships only with other state health-related agencies. It has also established working arrangements with certain private interest groups and OHSA (to be discussed below). In particular, OHPC has informal relationships with the Oklahoma Hospital Association, the Oklahoma Nursing Home Association, and the Oklahoma Medical Association for the sharing of data and input into state health planning.

It should be noted that OHSA has not taken any measures other than those specified in the Act to involve the general public in its planning processes. All meetings of the OHPC and the SHCC are open to the public, a public hearing on the State Health Plan is required, and members of the public may present testimony to the OHPC on C/N and 1122 applications. But OHPC appears to rely on the OHSA planning process for broadly based public involvement.

OHPC, then, has used the formal organization established by P.L. 93-641 to involve other state health-related agencies in the P.L. 93-641 planning and regulatory processes. Its primary goal appears to be insuring that the interests and prerogatives of state government are represented and protected in processes in which the locally-oriented HSA plays a major if not dominant role. This may be a necessary consequence where there is only one HSA in the state. In such a situation, there are two independent planning agencies with the same planning jurisdiction, but with different constituencies. OHSA sees itself as representing the interests on its Governing Board and OHPC sees itself as representing the interests of state government. The two interests will conflict. OHPC envisions that the modifications it has made in the formal P.L. 93-641 organization will minimize this conflict, or at least create a situation in which state government interests are represented in the final decision stage.

OHSA/OHPC Interrelationships

OHSA and OHPC have, of necessity, developed an extensive set of working relationships in the course of implementing P.L. 93-641. These relationships appear to be designed to (a) avoid unnecessary duplication of effort and (b) insure that their interests are represented in the regulatory decisions made under the Act. Because the agencies have the same planning jurisdiction, they realize they must work together to avoid duplication of effort. However, they also realize that, because they represent essentially different constituencies, their interests will, at times, conflict. The agencies feel that this conflict was envisioned in P.L. 93-641 and that it should be resolved through the structures and processes established in the Act. They have not undertaken extraordinary measures to eliminate this conflict. Rather, they have apparently decided that conflict between them should be resolved through procedures specified in the Act.

The most obvious case where OHSA and OHPC have worked together to avoid a duplication of effort is in the area of planning. The relationship which has apparently developed is that OHSA has assumed primary responsibility for health planning in Oklahoma. It has instituted a process for developing an HSP and AIP based on a statewide assessment of health needs. OHPC appears ready to let the HSP stand as the basis of the State Health Plan. It has not undertaken separate efforts to assess statewide health needs nor has it attempted to unduly direct the OHSA planning efforts. Rather, it has concentrated on assisting OHSA in its planning through providing data and technical assistance and on developing the state government policy portion of the SHP. OHPC apparently feels that its interest in the SHP can be adequately represented when the SHCC approves the SHP or when OHPC adopts the SHP.

OHSA and OHPC have not, however, developed a similar division of responsibilities in the plan implementation or regulatory functions under P.L. 93-641. Both agencies feel that to represent their constituencies and interests in health planning adequately requires them to participate fully in the regulatory processes established in the Act. This is despite the fact that some representatives of OHSA have expressed a desire not to be extensively involved in health care regulation and despite the fact that it leads to some

duplication of effort. These dual regulatory reviews have, at times, led to conflict and strained relations between OHSA and OHPC. On at least two occasions, OHPC has overridden the recommendation of OHSA on Certificate of Need applications. On both occasions, OHSA has become extremely upset and considered appealing the OHPC decision to the state court system.

In each case, the conflict appears to be the result of OHSA and OHPC using different decision criteria in their C/N reviews. OHSA has based its decisions on the health care needs identified in its planning process and on quantified criteria of nursing home or hospital beds per 1,000 population. On these criteria, it has twice rejected applications for additional bed capacity. OHPC, on the other hand, apparently uses criteria in addition to identified needs and statistical measures. One observer stated that the Commission "searches for a rationale" to support applications in addition to viewing them on the basis of health plans. It is these additional criteria which have brought about the conflict between OHSA and OHPC.

These conflicts have not strained the relationships between OHSA and OHPC to the breaking point. Both agencies realize the conflict will occur but that they must continue to work together. For this reason, the conflicts will be pursued through the processes established in P.L. 93-641. To accomplish this, the Oklahoma C/N laws will need to be amended to allow OHSA the right to appeal OHPC Certificate of Need decisions. Both agencies feel that their role as independent planning agencies requires that they both perform these regulatory functions despite the potential conflicts.

In summary, when one examines the interrelationships which have been developed among the health planning agencies created by P.L. 93-641 and other actors in the health planning policy arena in Oklahoma, four primary characteristics are apparent:

- The two major planning agencies, Oklahoma Health Systems Agency (OHSA) and Oklahoma Health Planning Commission (OHPC), have largely divided the major actors with whom they have developed relationships. OHSA has concentrated on developing relationships with the general public and nongovernmental health related interest groups while OHPC has concentrated on developing relationships with state government agencies involved in health planning, including the Office of the Governor. Both agencies have developed relationships with the federal government.
- To a large degree, the relationships take place through the formal organizational structure and processes. While informal relationships have been developed, they do not appear to be the predominant form of input for the parties at interest.
- Both agencies view themselves as independent planning agencies whose purpose is to obtain advice and counsel from the major parties at interest, but to independently analyze that input as an advocate for a particular point of view.
- In relating to one another, OHSA and OHPC have developed a cooperative relationship designed to minimize any duplication of effort, but at the same time, insure the full representation of the interests of each. This has resulted in the major planning function being assumed by OHSA and both agencies performing the required regulatory functions. While some conflicts have occurred, the agencies accept them as being necessary to the implementation of the Act and will try to control such conflicts through the processes established in the Act.

Because of the diminishing role of the SACs and some of the unusual powers of the OHPC, it remains to be seen whether Oklahoma's arrangement will lead to a stable long-term system.

TEXAS

This section examines the interrelationships which have developed in Texas as a result of the implementation of P.L. 93-641. As in other sections we analyze (a) the relationships among HSAs and other parties, (b) the relationships among the Texas SHPDA and the Texas Health Facilities Commission (THFC) and other interested parties, and (c) the relationships between HSAs and the state agencies.

HSA Interrelationships

Because of the number of HSAs in Texas, the geographical expanse of the state, and the regional diversity within the state, the interrelationships among the HSAs and other parties at interest in health planning do not adhere to a consistent pattern throughout the state. There are, however, several features upon which we can comment.

First, Texas HSAs, both private nonprofit and public, appear to have made greater efforts to establish working relationships with general purpose local governments, either individually or as a group, through Councils of Governments. Local governments and COGs are often used as sources for obtaining nominees or appointments to HSA Governing Boards. This is the case with the Camino Real, South Texas, Northeast Texas, and Central Texas HSAs. In addition, some HSAs have relied extensively on COGs for data and technical assistance in planning, and in some cases, HSPs and AIPs have been based largely on previous COG planning efforts. Further, the South Texas HSA and the

Camino Real HSA have based their SACs on the COG areas which were grouped to form the HSA. The relationships, of course, extend further in the case of the two public HSAs, Permian Basin and Houston-Galveston, where the HSAs are organizationally subordinate to regional planning bodies. Another aspect of this use of COGs is the extensive participation of local public officials on HSA governing boards. These officials tend to be much more active and powerful than other consumer representatives.

This situation is largely the result of the strength of the substate planning system based on COGs which existed in Texas prior to the implementation of P.L. 93-641. Under that system, five COGs were designated 314(b) Comprehensive Health Planning Agencies, and the other COGs had planning subgrants from the state 314(a) CHP agency. COGs were also extensively involved during the organizational stages of most Texas HSAs. In addition, COGs are the focus of much health related planning in the areas of alcoholism, drug abuse, and aging. Because the COGs are the primary areawide planning agencies in the state, HSAs have found it advantageous to work closely with them.

Second, most Texas HSAs have developed a working relationship with a number of provider groups in the state. In contrast to Arkansas and Oklahoma, these relationships have been developed with county or substate provider groups rather than the statewide association. In particular, county medical societies and hospital groups have worked closely with the HSAs. The statewide provider associations have concentrated on monitoring the activities of the Texas SHPDA and THFC; they have also been involved with the Central Texas HSA because most of them are based in Austin, as is CTHSA. The state associations also provide much information on P.L. 93-641 and related activities in Texas to their substate counterparts. The activities of provider groups have been directed primarily toward obtaining formal representation on HSA Governing Boards, SACs, Task Forces, and other HSA working bodies. Provider associations are often relied upon for nominations and appointments to HSA groups.

Third, the Texas HSAs have responded in a fashion similar to the Arkansas and Oklahoma HSAs in attempting to involve health consumers or members of the general public in their planning processes. Most of the HSAs have formed some groups other than a governing board, such as SACs and Task Forces, to involve the general public. In doing so, they have not been able to rely on a statewide consumer organization. Rather, they have primarily used local governments and COGs for consumer appointees. Some minority groups have protested that their interests are not represented in a system which relies extensively on health care provider and traditional processes of public input. The HSAs confronted with this situation have generally tried to involve the protesting groups in the planning process by urging them to provide testimony and by appointing minority group members to the HSA Governing Board and other groups.

The final characteristic of HSA interrelationships in Texas is the degree to which dealings between the HSAs and the Dallas Regional Office of DHEW have resulted in conflict. There appear to be two major causes of these conflicts: (a) the Regional Office, acting as the agent of the central DHEW office in Washington, is sometimes seen by the HSAs as attempting to control local planning, and (b) the Regional Office is seen by some HSAs as impeding the ability of the HSA to implement the planning system they desire.

The first of these conflicts is not unlike what has occurred in Oklahoma and Arkansas. The National Health Planning Guidelines, in particular, are seen as federal attempts to control local planning, and the Regional Office, as a federal representative, is associated with the guidelines. In Oklahoma and Arkansas, however, it appears that the HSAs have seen the guidelines as the responsibility of Washington DHEW and have continued to rely on the Regional Office as their primary federal information source and contact. This dichotomy between the regional and central DHEW offices does not appear as clear with Texas HSAs.

This is probably due to the second cause of conflict between the HSAs and the Regional Office. Several Texas HSAs had their applications for full designation disapproved or had difficulty in getting their applications for redesignation approved. For example, the Permian Basin application for full designation was disapproved. The Permian Basin HSA feels this was because it was the first application for full designation in the Region and the Regional Office was unprepared to handle the application. Permian Basin feels the Regional Office was unjustified in denying the application without comment or having provided technical assistance. Houston-Galveston and Camino Real applications for full designation also were disapproved. In addition, the Central Texas HSA had difficulty getting its application for conditional redesignation approved because of disagreement with the Regional Office over the acquisition of computer services and the ability of the HSA to contract with COGs for services. These and other disagreements have caused some Texas HSAs to view the Regional Office as something of an adversary. They feel the Regional Office is attempting to restrict their flexibility in designing a workable planning system. This has not, however, prevented all Texas HSAs from developing a cooperative relationship with individuals in the Regional Office, particularly project contract officers.

SHPDA and THFC Interrelationships

Like the Arkansas and Oklahoma SHPDAs, the Texas SHPDA has undertaken measures to involve other state agencies in its health planning process. In addition, it has taken steps to involve statewide associations of providers and others in its activities. It has not, however, devised a formal role for these agencies and interests in the decision-making processes established by P.L. 93-641 as is the case in Arkansas and Oklahoma.

To develop the statewide needs and state policy portion of the State Health Plan, the Texas SHPDA has established a planning process which involves a number of state agencies and statewide health related organizations. It has established an Interagency Task Force on Health Policy comprised of representatives of health related state agencies to aid in the inventory of state health policies, to obtain data for its planning efforts, and to assist in identifying statewide health needs and establishing priorities among those needs. In addition, the SHPDA has, through a questionnaire, solicited input from approximately sixty state agencies and statewide organizations on statewide health needs. The inventory of state health policies and identification of statewide health needs and priorities will be the basis of the statewide portion of the SHP. In addition, the SHPDA has arranged meetings between HSA staff, SHCC members, and those state health agencies whose state plans are subject to review by the SHCC.

A formal organizational role in the decisionmaking processes established by P.L. 93-641 has not, however, been developed for the other state health related agencies. These agencies have not been accorded membership on the SHCC as they have in Oklahoma and Arkansas. In addition, it is not possible at this time to determine the extent to which THFC will base its Certificate of Need decisions on the State Health Plan or other health plans. It is thus not possible to project the extent to which the involvement of these other state agencies will actually influence the decisions made under P.L. 93-641. It may be that state government interests will not be fully represented. Even though the other agencies' views have been solicited, lack of a formal vote on the SHCC or approval powers (as with the OHPC) mean that such agencies are in a much less strong position than in Oklahoma and Arkansas.

The Texas SHCC has physicians as Chairman and Vice Chairman. The strong position of physicians on the SHCC may, in part, be due to the somewhat autonomous nature of the THFC which runs the Certificate of Need program. Hospitals and consumers may feel that their interests will be more likely impacted by the THFC. The importance of the composition of the SHCC and the way it is structured in reflecting various interests and in deciding on the SHP is yet to be shown. It will be interesting to see the response of the other state agencies in Texas to the SHP that is finally adopted, and compare that to the response in Arkansas and Oklahoma, where the representation is more formal.

HSA/State Interrelationships

The relationships between the Texas HSAs on the one hand and the SHPDA and THFC on the other are such that it appears that two separate planning systems and a regulatory system separate from both planning systems could result. The agencies have worked together on an informal basis, largely in response to problems which have arisen. However, they have not developed any formal interrelationships for integration of the substate HSA planning process with the statewide SHPDA process, nor have systems been developed for integrating the planning processes with the regulatory decision of THFC, through which the plans could be implemented. Rather, each of the agencies has implemented the functions assigned them in relative isolation.

As stated, the HSAs and state agencies have worked together on an informal *ad hoc* basis. Generally, these relationships have been developed in response to problems which have arisen in the HSA planning process. In particular, the SHPDA and the HSAs have formed two *ad hoc* task forces in the early stages of the planning process; one to develop a minimum HSP/AIP data set, and one to develop a common HSP/SHP format. Neither of these task forces have been continued, and few, if any, other relationships have been developed for integrating the substate and state planning processes. The SHPDA has assigned a staff liaison to each HSA, but the function of this person is largely to provide technical and information assistance to an HSA rather than to attempt to link the planning processes of the agencies. The SHPDA has not been extensively involved in the HSAs' planning processes and the HSAs have not been involved in the SHPDA planning process. They operate largely independently of one another.

Likewise THFC operates in isolation from both the HSAs and the SHPDA. While THFC regularly informs HSAs of C/N applications from their areas and solicits their recommendations, no HSAs are currently reviewing and making recommendations on C/N applications. The Houston-Galveston HSA did so for approximately ten months but discontinued the activity to devote more resources to its planning efforts. None of the Texas HSAs studied desire to be extensively involved in regulation. They plan to delay such involvement until they are fully designated and are required to undertake such activities. THFC attempts to obtain data from the SHPDA, but has generally been disatisfied with that received. The lack of this working relationship between THFC and the health

planning agencies serves to separate further the planning and regulatory processes already bifurcated by the creation of a separate regulatory body. The two processes could be integrated if the plans developed by the planning agencies were the primary bases upon which the regulatory decisions were made. Previous State Medical Facilities Plans have been used by THFC in its decisions, but have been found often to be outdated and not related to the decisions at hand. There is little indication of what role future plans developed under P.L. 93-641 will play in THFC decisions.

In short, the integrated substate/state health planning and regulatory system envisioned in P.L. 93-641 has not, to date, developed in Texas. Rather, what appears to be developing are three systems—a substate planning system, a state planning system, and a state regulatory system—each operating largely independently of the others. Some envision that these three systems will be integrated through processes or requirements established by P.L. 93-641. That is, the substate and state level planning efforts will be integrated into a comprehensive State Health Plan by the SHCC and these plans will form the basis of THFC regulatory decisions. However, neither of these two conditions is assured, and it is unclear at this time that either will result. The SHCC has not given a clear indication of the direction it will take in integrating the planning efforts, or if it will attempt to do so at all; nor has THFC given a clear indication of the role the plans will play in its future decisions.

Thus, despite the fact that the structural requirements of P.L. 93-641 have been met in Texas, it is impossible at this juncture to determine if the integrated planning and regulatory system envisioned in the Act will result. Instead, three separate systems might be established, each serving different purposes.

CONCLUSION

The purpose of this chapter has been to examine the interrelationships which have developed between the HSAs and SHPDAs on the one hand, and the other parties at interest in health planning on the other, during the implementation of P.L. 93-641 in the three states reviewed in this study. The intent was to identify what parties at interest have been involved in the agencies' planning and regulatory processes and what measures were taken to involve those parties. The chapter also examined the interrelationships which have developed between the HSAs and SHPDAs in each state to identify how the states intend to achieve the integrated areawide and state planning and regulatory process envisioned in the Act.

We found that HSAs have concentrated primarily on involving health care providers and consumers in their processes. They rely extensively on HSA Governing Board membership to accomplish this, along with the public hearing and meeting requirements of the Act. In addition, most HSAs have augmented the formal Governing Board structure by forming SACs, Task Forces, and Advisory Councils to involve persons other than Governing Board members. Most HSAs solicit nominations for the Governing Board and other groups from a large number of individuals and groups, and feel this achieves widespread involvement in the agency.

SHPDAs, on the other hand, have concentrated on involving other state health related agencies in their processes. This involvement has generally taken the form of surveys, interagency task forces, and data sharing arrangements. In addition, Oklahoma and Arkansas have appointed state government officials to the SHCC to insure that state government interests are represented in the P.L. 93-641 processes. All SHPDAs appear to be relying on the HSAs to bring the general public into the planning and regulatory processes.

In each state, the HSAs and the SHPDAs have formed a working relationship with one another. This relationship generally consists of joint working groups, data sharing arrangements, and avenues of informal communication. However, in no state was there found a structural arrangement which we are confident will lead to the integrated areawide and state planning and regulatory system envisioned in the Act. Rather, it was generally found that there are two separate planning and regulatory systems operating. There was little indication of how the integration will take place. The SHCC will, of course, play a major role in the integration, but in each state, the SHCC is of such recent origin that it is not possible to project the role it will play.

It should be clear that all of these relationships and interrelationships should facilitate more effective health planning and regulation. However, if there is no consensus as to objectives or means for achieving them, the interrelationships will indeed be strained.

CHAPTER VII

SUMMARY AND CONCLUSIONS

SUMMARY

The Congress enacted in 1974, and is in the process of reenacting, a law which establishes a three level health planning system in the United States, designed to ration resources while gaining its legitimacy from the broad-based participation of consumers and providers of health care in advisory and decisionmaking functions at all levels. In our study of three states and nine Health Systems Agencies in the fall and winter of 1977-78, we found, three years after the passage of the law, that in establishing both the structure and in performing the functions mandated by P.L. 93-641, there was significant diversity.

Before presenting our conclusions regarding the impact of this law and its effectiveness in achieving its objectives, it will be helpful to summarize our findings with regard to the implementation of P.L. 93-641 at the state level, and the HSA level, and the kind of interrelationships in health planning which have been fostered in each of the three states.

The State Level

In all three states, enabling legislation was passed which created new and strikingly different insitutions for health planning at the state level. Although the Arkansas SHPDA was placed in the State Department of Health for administrative purposes, it is under the supervision and control of the Governor, and the Director of the SHPDA serves at the Governor's pleasure. The Oklahoma Health Planning Commission (the SHPDA) is under the direct control of the three ex officio Commissioners, who have the unusual power of adopting the State Health Plan after the SHCC has approved it. In Texas, approval was obtained from the Secretary of DHEW to create a largely autonomous agency, the Texas Health Facilities Commission, to administer the Certificate of Need functions at the state level, while the SHPDA remained a branch of the State Health Department.

The approach to constituting a SHCC also differed significantly in each state. In Arkansas the Governor increased the HSA representation to 68 percent and, though not required by state law to do so, appointed the Directors of the State Departments of Health and Human Resources to the SHCC. In Oklahoma the non-HSA representatives on the SHCC are rather specifically designated, and the Governor's influence is somewhat maintained as he appointed the HSA representatives on the SHCC and he retained the right to remove a member of the SHCC for arbitrarily or capriciously ignoring his statements regarding the State Health Plan. In Texas there is some ambiguity of authority since the SHPDA is part of the Texas Department of Health Resources and administratively responsible to it, while it is responsible in a policy direction sense to the SHCC. This is complicated further by the existence of the Texas Health Facilities Commission which is more or less free-standing, and whose Commissioners are appointed by the Governor. The Texas SHCC does not contain representatives of other state level health related departments among its members as do those in Arkansas and Oklahoma.

These state level institutions are charged with carrying out the mandate of preparing state health and medical facilities plans, administering Certificate of Need and 1122 programs, and undertaking appropriateness reviews and reviews of state agency plans and applications. Here we found some similarity in the approach to the State Health Plan and, for the most part, a limited record of performing the regulatory and review functions entirely within the context of P.L. 93-641.

With regard to planning we found that in each state, although the SHCC has the responsibility to coordinate plan development between the HSAs and the SHPDAs, often the SHCC was the last entity formed. Also, the federal government was slow in issuing guidelines (May 1977) for the development of a State Health Plan, while at the same time it was putting pressure on local HSAs to develop their HSPs if they wanted to be permanently designated.

In general the three states studied have accomplished the following activities in developing a State Health Plan:

- developing planning guidance consisting of, at least, a common HSP/AIP format;
- Establishing a process for the identification of statewide health needs and policies;
- providing technical and informational assistance to HSAs in the development of their HSPs; and

– establishing a committee of the SHCC to guide the development of the SHP.

It should be noted that at the time of this study, none of the three states had reached the point of attempting to integrate the HSPs and the statewide planning activities into a State Health Plan. The SHPDAs in these states had not completed the preliminary State Health Plan and in only one state, Arkansas, had all HSAs developed their HSPs. Indeed, there is reason to doubt that integration of HSPs with statewide health planning activities will necessarily take place. It may well be that the SHPs will be compilations of the HSPs with an appended section on statewide and state government needs and policies. Whether such documents can be used effectively to ration resources is open to question.

With regard to the State Medical Facilities Plan, all three states have built on previous Hill-Burton facilities planning efforts, updated their facilities inventories, reviewed and modified formulas for the allocation of facilities, and published interim medical facilities plans. These interim plans are designed to serve as data documents for developing HSPs and the SHP. Texas deviates somewhat from this pattern in that its interim facilities plan will be a two-volume document of which only the first, an inventory of facilities and utilization, has been published. The second volume, currently being prepared, will provide formulas for the allocation of facilities. In addition, all states use a Medical Facilities Committee of the SHCC to assist the SHPDA in developing the SMFP.

The medical facilities planning process is being delayed somewhat in all three states for the same reasons: federal guidelines have not yet been published, the HSPs are not complete in any state but Arkansas, and the State Health Plan is not complete in any of the states. Although the State Medical Facilities Plan is needed for input into Certificate of Need and 1122 reviews, this delay is not seen as crucial because no funds for grants under Title XVI have been appropriated by Congress. It is not apparent that HSPs will be used to a great extent in development of the SMFP.

With regard to review and regulation, the three states have all enacted a Certificate of Need law, although neither Texas' nor Oklahoma's laws have yet been certified as being in conformance with federal regulations. In the case of Oklahoma this is because the appeals procedure under the nursing home C/N law does not conform, and because the newer C/N law does not explicitly cover all necessary health care facilities. In Texas, the problems have been that the appeals mechanisms based on the Texas Administrative Procedures Act do not permit a definitive decision by the appeals body, that the HSAs are not explicitly given standing to appeal contrary decisions by THFC, and that HSAs are only allowed forty-five days rather than the statutory sixty days to comment on an application for Certificate of Need. These disagreements will have to be ironed out or the laws changed before the programs in these two states can be certified. In Arkansas the 1975 Arkansas legislature passed a C/N statute which, in accordance with the recommendation of the Arkansas Hospital Association, contained minimal procedural detail. This flexibility allowed the SHPDA to develop a C/N program which met the requirements of P.L. 93-641 and subsequent regulations, and Arkansas became the first state in the nation to have a fully approved Certificate of Need law.

In carrying out the Certificate of Need function there has been more explicit disagreement in Arkansas and Oklahoma than in Texas. In Arkansas, of the twenty applications disapproved by the SHPDA, ten were recommended for approval by the HSAs. In addition, the SHPDA approved seven other applications when the HSAs had recommended that they be disapproved. None of these contrary decisions has been appealed. Now that all four HSAs have been permanently designated, however, it may be anticipated that such action by the SHPDA will more commonly lead to appeals by the HSAs.

In Oklahoma, although the HSA has not been permanently designated, there has been notable disagreement between the HSA and the SHPDA on two occasions. In the first case OHPC approved a C/N for a small nursing home after OHSA had recommended that the C/N be denied. The OHPC apparently approved the C/N because the nursing home was to be used primarily by members of a religious order which has a nationwide membership and whose national headquarters are located in Oklahoma City. It was apparently felt that the needs of the order overrode the fact that there was already a surplus of nursing home beds in the area in which it was to be located. OHSA considered appealing the OHPC decision, but felt that until its HSP was complete it did not have a firm basis for its appeal.

The other occasion concerned a Certificate of Need application from Oral Roberts University. Because Tulsa, by the 4.0 beds per 1,000 standard, had a 1,000 bed surplus, in February 1978, OHSA recommended disapproval of the application. However, in April 1978, OHPC issued a Certificate of Need for 294 of the requested 777 beds. The OHPC decision was based, at least in part, on the contention of the applicant that patients would be drawn from a multistate area rather than just the Tulsa area because of the desire of patients to participate in the religious aspects of medical care in the City of Faith Hospital.

In approving the application, the Oklahoma State Health Planning Commission found that there would be a national clientele for this hospital, who wanted access to this particular approach to medicine. The Commission went on to say that although the Tulsa Hospital Council alleged a good deal of overbedding, several existing Tulsa hospitals "either have applications pending or indicate they intend to

file applications for Certificates of Need to modernize beds that are outdated or out of service as substandard." Finally, the OHPC stated that since the $55 million project would be cash financed, the savings to the patients would be substantial and the daily rate would not have to include interests payments.

The OHPC decision has been appealed to the state court system by the Tulsa Hospital Council, which is asking that the decision be overturned. The OHSA Governing Board has elected not to join in the appeal. It may be anticipated that once OHSA is fully designated, it will take an even more active part in the Certificate of Need process. It may be hypothesized that OHSA is so adamant about its role in Certificate of Need in part because it also serves a statewide area and presumably believes that it also takes statewide issues into account.

In Texas we found little interest on the part of the individual HSAs in taking part in the Certificate of Need process until they are fully designated. Much potential conflict was avoided by the grandfather effect of the Texas law which permitted all C/N applications filed within 120 days of passage of the Act to be exempt from review, provided that development of the service began prior to February 1, 1976, and that substantial progress was made by January 1, 1977. From June 1976 through October 1976, a total of 900 applications for exemptions with project costs toalling $1.3 billion were received and approved. Subsequently a number of applications have been denied a Certificate of Need on the grounds that there was insufficient need.

The legalistic nature of the THFC proceedings may make it difficult, or at least costly, for HSAs to participate fully in the process. By February 1978, only the Houston-Galveston HSA had participated in proceedings before THFC. For approximately ten months in 1976, this HSA regularly retained counsel to act as its agent before THFC on applications within its jurisdiction, but it then suspended this activity to devote more resources to its planning functions. THFC regularly notifies HSAs of applications affecting them, but it receives few responses.

Because appropriateness reviews are not to be conducted until the HSPs are completed, and because final federal regulations were not published to govern the reviews until mid 1978, the process had not been implemented in any of the three states studied. The appropriateness review function, however, is not relished by many of the parties interviewed because of:

- confusion over the purpose of the review, with many observers believing HSAs and SHPDAs are required to close existing facilities which are found to be inappropriate;
- reluctance on the part of some to become extensively involved in the regulation of health care, particularly of existing facilities; and
- doubt that numerical criteria for the distribution of health services adequately serve the needs of rural areas.

Despite the absence of federal regulations regarding the review of state agency plans and applications, all three states have made preparations to undertake this responsibility. In Arkansas, the State Health Plan Committee of the SHCC is responsible for reviewing the state plans and applications of other state health related agencies as required under P.L. 93-641. The Committee has reviewed and recommended approval of the State Mental Health Plan and the State Developmental Disabilities Plan. The full SHCC approved both plans. In addition, the Committee has received an orientation to the federal programs it will be reviewing. Several times during its deliberations, the Committee has expressed its inability to fully review the plans because of the lack of a State Health Plan.

The OHPC appears to have undertaken the most extensive activities in Oklahoma in preparation for the discharge of this function. The Executive Director of the OHPC was early in recognizing the potential conflict this authority could create, and took steps to try to defuse any conflict. After the formation of the SHCC Committee on the Review of Program Proposals Administered by State Agencies, committee members reviewed the federal requirements placed on each of the programs subject to review, and met with appropriate state officials to discuss the programs. The committee also reviewed the Oklahoma State Drug Abuse Plan and the Oklahoma State Mental Health Plan on an advisory basis only.

At the time of our research, Texas state agencies had not undertaken much work to prepare themselves for the exercise of this review function. The SHCC had formed a committee, the Application, Budget, and Project Review Committee, to discharge this function. In addition the SHPDA was developing procedures and criteria for these reviews, which it would submit to the SHCC for approval. It is felt by the Texas agencies that these procedures and criteria should await the completion of the HSPs and SHP.

The HSA Level

At the local, or HSA, level we also found a great deal of diversity regarding the structural arrangements for advice and decisionmaking, the extent to which health plans had been prepared, and the degree to which the agency was ready to begin implementing the plans.

The diversity of arrangements in the HSAs we studied is summarized in Table 2 on pages 49 and 50. Our sample of nine HSAs included one statewide HSA, Oklahoma; two entirely rural HSAs, Delta Hills and Permian Basin; two public HSAs, Houston-Galveston and Permian Basin; and HSAs which incorporated a range of other characteristics such as Subarea Councils and Executive Committees which

we thought merited examination. Because the time since plan development has been somewhat limited, we cannot judge precisely how these different arrangements have affected the performance of these agencies. It is possible, however, to make some comparisons between the three states and to make some limited observations on the impact of structure.

In Arkansas, where the HSAs are former or combinations of former CHP (314[b]) agencies, the transition from the CHP program to P.L. 93-641 has been smoothest and most rapid. The directors and much of the staff of the two agencies we studied were the same as they had been under the CHP program. Both agencies had standing committees and neither of them found it necessary to form subarea councils. Active participation of ACORN and the development of a General Corporate Body distinguish the Central Arkansas HSA and its ability to obtain public participation.

In general it appears that the Arkansas HSAs included in this study have primarily channeled the involvement of other parties at interest in areawide health planning through the formal organization established in P.L. 93-641. Both HSAs solicit nomination for governing board membership from a wide variety of groups and individuals including providers, consumers, and local government officials. Beyond this, however, the HSAs have made few efforts other than public meetings, public hearings, and the Corporate Body of CAHSA to obtain widespread involvement.

In Oklahoma one HSA took the place of seven fully designated and funded 314(b) health planning agencies and four additional Economic Development Districts which did not acquire CHP 314(b) funds. In Oklahoma there is a Governing Board of thirty with six subarea councils corresponding to the state's six congressional districts. Only one of the seven directors of the 314(b) agencies joined either the HSA or one of the subarea councils, although a number of former employees of the 314(b) agencies are still employed by one or another of these entities. The process of nomination and selection of board members is quite formal. Once the HSAs were created, the HSA attempted to insure that virtually all input into health planning came through this formal organization, from the SACs up to the HSA Governing Board, or through other formal processes such as public hearings.

This reliance upon the SACs is demonstrated by the fact that they were the basic vehicle through which the initial HSP and AIP were developed. Appointments to the OHSA Governing Board come largely from nominees of the SACs. Eight persons are nominated for each open position: six of the nominees come, one each, from the SACs. And, membership on all standing committees of OHSA is limited to members of the Governing Board or the SACs.

The predominance of the formal organization serves to limit the point of contact among the parties at interest in health planning to those under OHSA's control. It then becomes the primary arbitor of disputes and can develop a consistent health plan which it feels meets the needs of the state rather than reflecting the viewpoint of any interest group. Currently however, since the basic planning documents are completed, OHSA is taking steps to diminish the role of the SACs. Once this is done OHSA must find some other way to obtain much of the input and legitimation they have had from the SAC. Otherwise if the other parties at interest feel they are not adequately involved, OHSA may lose some of the cooperation it appears to have received from other groups.

In Texas, because of the number of HSAs, the geographical expanse of the state, and the regional diversity within the state, it is not possible to generalize about a consistent pattern. Both private nonprofit and public HSAs in Texas appear to have made greater efforts to establish working relationships with general purpose local governments, either individually or as a group, through Councils of Governments. Two of the six HSAs studied are arms of preexisting Councils of Governments, using essentially the same staff as before. The other four use local governments and COGs as sources for nominees or appointments to HSA Governing Boards. Some HSAs use COGs for data and technical assistance in planning, and the South Texas and Camino Real HSAs have based their SACs on the COG areas which were grouped to form the HSAs.

Although many of the individuals who had been active in the COGs in health planning moved over to the HSAs, there were only five funded 314(b) agencies in the State of Texas, and the relative level of expenditures and staffing was smaller than in the other two states. The reliance on COGs is not surprising since COGs were extensively involved during the organizational stages of most Texas HSAs. In addition, COGs are the focus of much health related planning in the areas of alcoholism, drug abuse, and aging. Because the COGs are the primary areawide planning agencies in the state, HSAs have found it advantageous to work closely with them.

Most Texas HSAs have developed a working relationship with a number of provider groups in the state. In Texas, although providers are very active on every board, there are two groups of consumers who also participate actively. One is elected public officials, who are far more prevalent on Texas HSAs, who are not afraid to speak up, and who bring skills and resources of their own to the process. The other includes representatives of organized consumer groups such as ACORN in Dallas, and the South Texas Health Consumers Association which has been active in the South Texas, Camino Real, and Central Texas HSAs. The particular nature of P.L. 93-641 may make such consumer groups and

provider groups more important in decisionmaking than they would be under a system of general government.

In the performance of their functions, the HSAs in these three states are at quite different stages. Comparisons by state with regard to plan development show that of three states, Arkansas has made the most progress. In October 1977, all four Arkansas HSAs received full designation status and had their HSPs and AIPs accepted by DHEW.

Oklahoma's planning process has been a joint effort of the HSA and its six Subarea Advisory Councils. An HSP and an AIP were not completed at the time of the interviews in November 1977. However, they were anticipated for the spring of 1978. Planning efforts at OHSA have intensified as it has become apparent to its members that the HSA's powers vis-à-vis the OHPC and the SACs regarding projects like the proposed City of Faith Hospital in Tulsa are limited as long as it is not fully designated and does not have an HSP and AIP accepted by DHEW.

Finally, the planning efforts of the six Texas HSAs in our sample have encountered several obstacles. Several of the HSAs have had their initial plans rejected by the Regional Office of DHEW. Permian Basin's plans, the first to be considered by the Regional Office, were rejected in May 1977. Also, Houston-Galveston HSA's initial plans, using emergency medical services as a "microcosm" of the area's health system, were rejected in July of that year. Similarly, the Central Texas HSA's application for conditional redesignation for its second year was initially rejected and was accepted only after revision and resubmission. Finally, the Camino Real HSA had its application for full designation deferred for six months by the Regional Office.

The remaining Texas HSAs, the Northeast Texas and South Texas HSAs, have not produced their first plan documents. The initial planning processes were underway at the time of our interviews and completion was expected shortly. The Northeast Texas HSA has been delayed by several internal and external events, while the South Texas process has been complicated by the heavy involvement of its four SACs in the Plan Development process, and the instability of its staffing arrangements.

The performance of the plan implementation function by the HSAs in our sample has varied from those conducting neither review nor encouragement activities to others which are actively considering C/N, 1122 and proposed uses of federal funds reviews and undertaking some encouragement activities. None of the nine HSAs has begun appropriateness reviews.

Of the three states, the HSAs in Arkansas are farthest along in their performance of the plan implementation function. The two Arkansas HSAs in the sample have actively performed reviews, have attempted to exercise their disapproval powers, and are not reluctant to adopt a regulatory, restrictive stance. In fact, one of the Central Arkansas HSA's chief concerns during the interviews was the nonexistence of federal regulations regarding HSA review and approval/disapproval of proposed uses of federal funds. Cognizant of the fact that their agency was one of the first in the country to attempt to exercise these powers, they were seeking to buttress their review powers with federal regulations that were not yet written and available health system development funds which were not yet appropriated.

In Oklahoma the statewide HSA has been somewhat active in reviewing new institutional services, but the OHSA has lacked a right to appeal and a fully designated status in its dealings with the SHPDA, the OHPC.

Finally, in Texas only three of the six Texas HSAs have been active in plan implementation. Two Texas HSAs have been conducting the review and comment function for Certificate of Need and proposed uses of federal funds reviews. A third HSA was just beginning to put its reviewing apparatus into operation at the time of our interviews. Nevertheless, because all lacked fully designated status, none of these three HSAs were attempting to exercise disapproval powers over the federally funded categorical programs.

CONCLUSIONS

This study has examined the process of implementation of P.L. 93-641 in three states and nine health systems agencies. Although it is far too early to predict just how these new institutions will work out, especially in the light of amendments currently being considered by Congress, it is possible from our research to point out some difficulties which have emerged in the implementation of this new law, to make some general points regarding the structure of decisionmaking and authority, and finally to make some suggestions regarding improvements which should perhaps be introduced.

First, in regard to implementation difficulties, it soon became apparent to us that although enormous effort had been expended by DHEW and by the state and local agencies in order to achieve full designation, the law's original time frame of only two years for conditional designation appeared to be unrealistic in many cases. While all local and state agencies were able to organize and apply for funding relatively soon after P.L. 93-641 was passed, they have encountered numerous problems which have prevented achievement of the level of performance necessary to demonstrate to DHEW the agency's ability to perform the functions mandated by the law. These problems include inexperience of both staff and board members, lack of guidelines from DHEW, incomplete machinery at the state level, and late guidelines from the SHCCs.

Other difficulties lie in the unrealistic expectations of

many participants regarding the extent to which this legislation in general and the HSAs in particular will affect the rapid escalation in health care costs. The federal priority of cost containment, while always a priority, has received increased emphasis under the Carter administration. The Certificate of Need process and appropriateness review are directed ultimately at achieving cost control by reducing or limiting facilities and services. The National Health Planning Guidelines attempt to set appropriate levels of facilities and services on a nationwide basis. However, local HSAs have reacted strongly to the guidelines, and in many cases, with a lack of enthusiasm to the C/N and appropriateness review functions. This is due primarily to the HSAs' emphasis on their priority of local accessibility to medical facilities and services. When HSAs do actively participate in recommending against a particular activity or facility, it is not necessarily for cost containment reasons, but often to restrict competition. Even if the goal of cost containment were accepted by all parties, however, other factors still would prevent the system from achieving the goal.

In particular, HSAs have review and approval authority, but only over a limited number of federal health grants. The Certificate of Need process covers only new institutional services and facilities, and as yet the HSAs' role in appropriateness review is ill defined. The focus on new institutional services and facilities leaves much of the health care delivery system outside the control of both the HSA and the state; private physicians' offices, existing facilities, and redundant equipment and facilities are unregulated. P.L. 93-641 was instituted to affect the cost and organization of the entire health care delivery system, but in fact the planning and regulatory functions mandated affect only a small part of the system.

The federal government also must share responsibility for making its goal of cost containment unachievable. By financing health care facilities and services on a cost and a categorical grant basis, the federal government provides little or no incentive for cost containment. Indeed the proliferation of such equipment as CT scanners would not be so prevalent if the government reimbursed $20 or $30 rather than $150 per scan. Localities are not allowed to redirect federal money for use where they determine it is needed. Without the ability to control the budgets or the reimbursement rates of facilities and services, the state and local governments cannot be expected to significantly affect costs in the context of this free flowing federal and private insuror funding, even if they become very stringent in administration of Certificate of Need.

Another reason why the system as now constituted will have reduced impact is that the federal level is not unified at present. Congress has displayed a tendency to ignore DHEW-initiated goals and be more responsive to local constituent agency needs. This attitude results in goal conflict at the federal level, with different branches of government emphasizing different goals at different times. While this is confusing to the local agencies which must adjust to these priorities, it also undermines the system by constantly changing the focus.

Finally, it became obvious to us that the relative definition of roles of the HSAs, SHPDAs, and SHCCs in both planning and regulation will be ongoing for the next several years. So far, HSAs have not been fully designated; therefore, they have not had standing in appealing Certificates of Need, nor have they had review and approval powers. SHCCs have not yet attempted to integrate HSPs into State Health Plans and Statewide Medical Facilities Plans which include statewide initiatives and needs. Nor have the SHPDAs as yet tried to use the planning documents for Certificate of Need decisions. Until these activities begin to take place, the workings of this system cannot be truly evaluated. It appears to us that the Certificate of Need authority does belong at the state level, where there can be a large and effective staff, and where at least there is Constitutional authority as well as well-defined political structure, authority, and accountability. This does not preclude a role for the HSAs and their plans in this process, but it does raise the question of whether they should have the final say.

Some questions may be raised regarding the structure of decisionmaking and authority under this act, as it tends to undermine the effectiveness of market forces and of the organs of general government. As with any regulatory activity, there is no question that the program is expensive to administer, and that under it there will be entities with vested interests in maintaining the status quo of the regulation itself.* Nevertheless, as Christa Altenstetter points out in a recent book on health care regulation in Western Europe:

> In efforts to contain costs through regulation, utilization review, reimbursement methods, planning and other types of intervention, most countries are developing more direct and/or indirect controls over hospitals and other health facilities (public and/or private). In summary, we notice increased public intervention in a sector that, except for the nationalization of financing mechanisms for health care, has been relatively undisturbed as compared to other

*See Robert Helms, "Regulating the Cost of Health Care: Can We Learn From Experience?" in *Health Care Delivery Systems in North America: the Changing Concepts*, (Windsor, Ontario: University of Windsor Press, 1977).

> functional policy areas, even in political systems where the public sector has played a dominant role.*

The reason for this increase in activity is that as entitlements to high quality health care have been made universal and are increasingly being funded at the national level, the cost escalations have been very difficult to control. Given the private and voluntary activity which so permeates the health sector in the United States, it may well be that agencies such as HSAs are the only way in which the consent and expertise of the providers can be obtained for intervention in this area. It remains to be seen whether the complex representational arrangements and somewhat undefined authority of HSAs will be effective.

Finally, as a result of our study of interrelationships under this act, two final points can be made. First, there appear to be inadequate mechanisms in P.L. 93-641 for coordination among levels of government. While most SHPDAs made use of task force or *ad hoc* arrangements to obtain HSA input and to share information, these arrangements have been motivated by particular problems or tasks and do not represent long-term or permanent devices. As many HSAs interpret the law as mandating local planning, one might expect HSAs to resist a formal coordinative mechanism. However, our research indicates that the lack of such a mechanism might result in disjointed planning and/or lead to conflict when the SHCC attempts to integrate health systems plans into a state health plan.

The same lack of coordinative mechanisms exists on the state level as well. While Oklahoma and Arkansas have taken steps to ensure coordination through formalized state agency representation on the SHCC, other states have not used this mechanism extensively. As a result, reliance has been placed on informal solicitation of input and communication. Although the effectiveness of either the formal or informal coordinative mechanisms has not been tested, it would appear that they might figure prominently in the successful development and implementation of the State Health Plan.

Second, P.L. 93-641 and the implementing regulations do not appear to provide adequate mechanisms for coordinating the State Health Plan, State Medical Facilities Plan, and Certificate of Need process. This lack is particularly critical in Texas, where the plan development and Certificate of Need functions are carried out by separate state agencies. However, even in those states in which the two functions are performed by the same agency, there is no guarantee that the necessary linkage between the two functions will result. In fact, there is reason to believe that the two functions are inherently difficult to coordinate within the confines of P.L. 93-641.

Even if these difficulties are resolved, we expect, as did virtually every person we interviewed, that the current configuration of institutions and powers enacted will probably not be the long-term set of arrangements. How health planning, regulation, financing, and quality control will finally be arranged will depend to a great extent upon our ability to come to some consensus as to the priorities we wish to place upon the system.

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*Christa Altenstetter, "The Impact of Organizational Arrangements on Policy Performance," in *Changing National-Sub-National Relations in Health: Opportunities and Constraints*, USDHEW, Fogarty International Center, 1978.

GLOSSARY

Annual Implementation Plan (AIP): The National Health Planning and Resources Development Act (P.L. 93-641) requires health systems agencies to write and update yearly a document that sets out short-range objectives to advance a health service area toward long-range goals in the Health Systems Plan.

Arkansas Act 558: The enabling legislation in Arkansas which provides for the establishment of the SHPDA in the State Department of Health for administrative purposes, but under the direct supervision and control of the Governor.

Bureau of Health Planning and Resource Development (BHP&RD): The Bureau of Health Planning and Resource Development was created in March 1975 as a component of the Public Health Service's Health Resources Administration. This Bureau was given major responsibility to implement P.L. 93-641.

Certificate of Need (C/N): The requirement that an applicant for a new facility or program or level of expenditure greater than a specified amount obtain a certificate from an appropriate state agency before proceeding with the expenditure of funds.

Comprehensive Health Planning (CHP): The Comprehensive Health Planning and Public Health Service Amendments (P.L. 89-749) provided for (1) under 314(a), formula grants to the states for development of comprehensive health planning programs administered by a single designated state agency, which would be advised by a broadly representative state health planning advisory council; (2) under 314(b), authorization of grants to local public or private nonprofit organizations to cover up to 75 percent of the cost of preparing local plans; and (3) under 314(c), authorization of project grants to public or nonprofit private institutions or other organizations for training, demonstrations, and studies.

Conditional Designation: All HSAs had to operate under a conditional designation agreement for at least one year before they could become fully designated. During the period of conditional designation, an HSA must perform a minimum set of functions concerning data analysis, planning, coordination, and the review of new institutional health services proposed for its area, and it must maintain a governing board which meets all legal requirements.

Health Systems Agency (HSA): An organization (private nonprofit, public, or unit of local government) that meets requirements and responsibilities spelled out in the National Health Planning and Resources Development Act of 1974. Health Systems Agencies study the health needs and resources of their health service areas, write plans articulating long-range goals to meet needs with resources (existing and future), see the plans through to completion with Annual Implementation Plans setting out short-term objectives, review applications for federal health dollars, and investigate and report on institutional health care.

Health System Plan (HSP): A description of health needs and resources in the health service area, prepared by the health systems agency, with long-range goals.

Hill-Burton Program: Hospital Survey and Construction Act of 1946 (P.L. 74-725). Tied the allocation of federal grants to subsidize the construction of hospitals and public health centers to a formula grant to states and a state plan which was designed to meet those needs.

National Council on Health Planning and Development: This is a fifteen member advisory council which consults with the Secretary of the Department of Health, Education and Welfare (DHEW) on national health guidelines and overall implementation of the act. The Council is also expected to study the implications of new medical technology that could affect the nation's health.

Members are appointed by the Secretary of DHEW for staggered six-year terms. At least three members must be drawn from HSA boards and three from SHCCs. The two political parties are given equal representation and at least one third of the members should represent consumers.

Oklahoma Health Planning Commission: The OHPC functions as the Oklahoma SHPDA. The Commission is comprised ex officio of the State Director of Public Welfare, the State Director of Mental Health, and the State Commissioner of Health. The Commission in turn appoints the director of the OHPC and has some additional powers regarding Certificate of Need decisions and approval of the State Health Plan.

Preliminary State Health Plan: The State Health Plan prepared by the SHPDA and submitted to the SHCC.

Regional Medical Programs: Regional Medical Programs were authorized by the Heart Disease, Cancer and Stroke Amendments of 1965. This legislation authorized planning grants, and had as its purpose the establishment of regional cooperative arrangements among medical schools, research institutions, and health care institutions to bring patients the benefit of the newest technologies in caring for these diseases.

Section 1122: This part of the Social Security Act, enacted in 1972, authorizes state health planning and development agencies to review proposed capital expenditures for health care. Expenditures which do not pass this review will not be eligible for federal reimbursement.

State Health Planning and Development Agency (SHPDA): These agencies are designated by the Governor of each state and approved by the Secretary of DHEW. Each of these agencies is responsible for preparation of a draft State Health Plan to be submitted to the State Health Coordinating Council. Each SHPDA is to assist the SHCC in its performance of its functions. The SHPDA also is to serve as the 1122 agency and to administer the Certificate of Need program. In addition the agency is to perform a review of the appropriateness of all health facilities in the state. With the Secretary's approval any of these functions may be performed by another state agency.

State Medical Facilities Plan: Any state wishing to obtain grants for the construction, modernization, or conversion of medical facilities under Title XVI of the Act must submit to the Secretary of DHEW for approval a State Medical Facilities Plan (SMFP). This plan should detail the number and kinds of facilities needed to meet the state's health needs and the number and type of facilities needing modernization or conversion.

Statewide Health Coordinating Council (SHCC): The SHCC is appointed by the governor. Sixty percent of its members must be HSA board members and at least half must be consumers. The SHCC reviews and co-ordinates Health Systems Plans and Annual Implementation Plans from all the HSAs in its state. It prepares an annual state health plan for the SHPDA's draft, reviews HSA budgets and reports its comments to the Secretary, reviews HSA applications for planning and resource development assistance, and advises the state agency on the performance of its functions. Finally, it reviews and approves certain state programs for funding under several federal programs.

Texas Health Facilities Commission: This agency was created for the administration of the Certificate of Need program and the conduct of the appropriateness reviews in Texas. The Secretary of DHEW gave permission for these functions to be carried out by this commission rather than the SHPDA.

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